Maternal and Child Health Services
Title V Block Grant

State Narrative for North Carolina

Application for 2009
Annual Report for 2007

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and certifications will be maintained on file in the Women's and Children's Health Section Office, located in Room C-7, 5601 Six Forks Road, Raleigh, NC.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Public input on the MCH Block Grant is obtained in several ways. It is posted on the WCHS website in July and partnering agencies (including Healthy Start Foundation, March of Dimes state chapter, Area Health Education Centers, etc.) are asked to review it and provide feedback to the Section Office. Another method is sharing portions of the document with members of the Family Council. Ongoing public input is obtained throughout the year as WCHS staff members work with both state and non-governmental agencies to improve programs and services.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The WCHS conceives of needs assessment as a continuous process, in which useful data, both quantitative and qualitative, relevant to the broad mission of the section are continuously being gathered and analyzed with an eye to adjusting the priorities and the activities of the section as appropriate. In addition to these day-to-day "micro" analyses of relevant inputs, the section utilizes formal needs assessment processes, such as the five year MCHBG needs assessment process, to review and titrate section priorities and activities. Examples of current needs assessment activities being conducted in FY07 and FY08 include revisions to the WCHS logic models, qualitative studies carried out by the Healthy Start Foundation on health care access for Latina women and Latina families with children/youth with special health care needs, and analyses of annual data releases such as state infant mortality rates, Pregnancy Risk Assessment Monitoring System (PRAMS) results, and the Child Health Report Card.

III. State Overview

A. Overview

In North Carolina, governmental health and social services are generally administered through autonomous county-level governmental agencies. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level. The Title V Program is housed in the Women's and Children's Health Section (WCHS) in the Division of Public Health (DPH), which is found in the NC Department of Health and Human Services (DHHS).

Managed care organizations (MCOs) are increasingly important service providers for populations with private health insurance. Although the use of MCOs for delivery of services to Medicaid recipients was implemented in a deliberate fashion, the shift from public to private sector provision of services to the low income population has had a profound impact on local public health agencies who have traditionally served as direct providers of publicly-subsidized primary and preventive health services. The emphasis on public-private partnerships is strong across the state, as "interested parties" determine what services are needed, and who can best provide them. The role of the state agency is to create and maintain state level partnerships, and to provide leadership and consultation to local decision-makers.

According to 2000 census data, the total state population has grown to 8,049,313, a 21.4% increase from 1990 census data. African-Americans remain the largest racial/ethnic minority group in the state, however the Hispanic/Latino population has increased over 300% from a reported 1.04% in 1990 to 4.7% in 2000. Based on 1997 poverty threshold information, 12.6% of North Carolinians live below the poverty level, with 18.6 percent of children living below the poverty level. The median household income for North Carolina in 1997 was $35,320, while the national average was $37,005. The unemployment rate for 2000 was 3.6%. In 2000, seventy-nine percent of the population over 25 years of age had graduated from high school, while 23% were college graduates. Further demographic data are available in the core and developmental Health Status Indicator forms found in Sections 5.4 and 5.6.

The NC DHHS is the largest agency in state government and is responsible for ensuring the health, safety and well being of all North Carolinians, providing human service needs to populations with mentally illness, deafness, blindness and developmental disabilities, and helping poor North Carolinians achieve economic independence. The Department has more than 19,000 employees and is divided into 24 divisions and offices which fall under four broad service areas - administrative, support, health, and human services. Three divisions account for most of the department's budget. These are the Division of Medical Assistance (which houses the Medicaid program), the Division of Social Services, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Additional divisions are the following: Aging; Budget, Planning, and Analysis; Child Development; Facility Services; Human Resources; Information Resource Management; Public Health; Services for the Blind; Services for the Deaf and Hard of Hearing; and Vocational Rehabilitation. The department is also responsible for managing the town of Butner. DHHS Offices include: Department Controller; Council on Development Disabilities; Economic Opportunity; Education Services; Internal Auditor; Legal Affairs; Property and Construction; Public Affairs; and Research, Demonstrations, and Rural Health Development. DHHS also oversees 19 facilities, including psychiatric hospitals, schools for the Deaf, and alcohol and drug abuse treatment centers. Direct health and social services are generally administered through autonomous county-level governmental agencies. There are 85 county or district Local Health Departments (LHD) providing health services for the one hundred counties that comprise North Carolina, as well as 100 county Departments of Social Services. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V

program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level.

The former DHHS Secretary, Carmen Hooker Odom, was appointed in January 2001. During her tenure, the Secretary has identified the following four top priorities for the Department: 1) improving and expanding early intervention services to infants and toddlers; 2) improving long-term care for the elderly and for people with disabilities; 3) reforming the state mental health system; and 4) eliminating health disparities. While all of these priorities impact the work performed by the staff of the Women's and Children's Health Section (WCHS), the most direct impact is felt by priorities one and four.

The NC Infant-Toddler Program, through the Early Intervention (EI) Branch, WCHS, DPH is the state lead agency for Part C of the Individuals with Disabilities Education Act (IDEA). The program completed its reorganization as of July 2004 with the eighteen Children's Developmental Services Agencies (CDSAs) serving as local lead agencies. Over two hundred new employees have been hired by the CDSAs to carry out their new service coordination role and to meet other oversight responsibilities. Early intervention services are being provided through contracts (approximately 400) with public and private agencies, organizations, or individuals. Regional Interagency Coordinating Councils and Local Interagency Coordinating Councils are carrying out their roles as advisory partners to the CDSAs as outlined in the Early Intervention Design Plan.

One of the specific values of the EI Reorganization is that of "easy access to services for families". Beginning July 1, 2004, all referrals are made directly to the CDSAs. The new, streamlined system for referral has worked well. The greatest challenge to timely evaluation of infants and toddlers at the present time is the increase in demand for EI services (reflected in a marked upsurge in referrals) combined with the lack of additional resources to meet the needs of these families. During FY04, there were 4719 infants and toddlers referred to the early intervention program. In the first six months of FY05 (July-December), there were 8144 infants and toddlers referred, which demonstrates a marked increase from previous years. In FY04, the total number of infants/toddlers enrolled in EI (10,978) plus the total number of preschoolers evaluated (6308) was 17,286. While this represents a slightly smaller total number of children served than in some previous years, this is a result of the program's increased emphasis on services for infants and toddlers, for whom the program is required to provide a wide range of services. Services for preschoolers, on the other hand, have been predominantly one-time evaluations, so service provision to infant/toddlers is more resource-intensive.

Several federal mandates have had a significant impact on the early intervention system and have broadened the opportunity for service provision to more children with comprehensive health care needs. The Child Abuse and Prevention Treatment Act (CAPTA), originally enacted in 1974, was most recently amended in the Keeping Children and Families Safe Act of 2003. CAPTA now stipulates that children under three years of age with substantiated abuse and neglect be referred to early intervention. North Carolina began this referral process in July 2004. The Infant-Toddler Program in partnership with the Division of Social Services provided statewide training in order to effectively implement this mandate. The Homeless Assistance Act Amendments of 1990 added "preventative services regarding children of homeless families or families at risk of homelessness" to the CAPTA language. The Individuals with Disabilities Education Improvement Act was reauthorized and signed into law December 3, 2004. This reauthorization echoes CAPTA legislation and also requires a referral to early intervention of young children affected by substance abuse and illegal drug exposure. Estimates from the Division of Social Services are that this will result in 5000 referrals annually; the early intervention program had been serving approximately 29% of these children, so more than 3000 of these children will reflect new referrals to the program. The law specifies that state provide outreach/child find to parents of premature infants; to parents of children with other physical risk factors associated with learning or developmental problems and to homeless shelters and similar settings. In order to meet the CAPTA and IDEA requirements, the Infant-Toddler Program's many partners in the Division of Public Health are more important than ever before.

While these changes are positive in terms of the goals of the state's early intervention program, this substantial increase and the potential for additional numbers of children to be served by the program poses very significant challenges. Because of the entitlement nature of early intervention, all eligible children must be served. The level of state funding has not increased in four years. The Infant-Toddler Program will continue to address its capacity needs over the next year by exploring additional resources, reviewing the program's current eligibility definitions, and reviewing the provision of evaluations to the preschool population.

In regards to the Secretary's fourth priority, eliminating health disparities, the WCHS collaborated with the other divisions and offices in DHHS to develop the DHHS Call to Action to Eliminate Health Disparities report. Three WCHS staff members served on the Steering Committee of Eliminating Health Disparities which developed the report. The purpose of the report is to provide a framework for understanding the magnitude of racial and ethnic disparities in NC and some of the social determinants of these disparities. The Call to Action focuses on the role of the Department in addressing these issues and provides specific action steps proposed by each division and office in the Department to address these issues. As part of the development of the report, the Disparity Program Assessment was conducted throughout the Department to examine divisions' and offices' key health disparities priority conditions or issues, service delivery and socio-cultural challenges, and health disparities focus areas. Results from the assessment in the DPH indicated a need to examine and address several socio-cultural challenges faced by numerous programs in the division, including language and communication difficulties, attitudes and values of providers and clients, and the need to improve health education/knowledge and awareness. The WCHS has developed a series of action steps incorporated into the implementation plan which fall under the nine key recommendations identified in the report. Examples of these action steps include: preparation of maternal health/family planning fact sheets on the health status inequities in NC to assist community-based organizations and other contractors to identify priority areas for health interventions; increasing the number of minorities served in the NC Early Intervention program; and documentation of best practices in serving the Hispanic/Latino community in WIC local agencies.

Children in NC whose family income is under certain federal poverty levels may be eligible for either Medicaid or NC Health Choice, the State's Child Health Insurance Program (CHIP). To qualify for Health Choice, children must be uninsured, be ineligible for Medicaid, and have a family income that is equal or less than 200% of the federal poverty guidelines. This program is administered jointly by DMA and DPH, with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. The program first started enrolling children in October 1998. Unlike Medicaid, however, Health Choice is not an entitlement program, thus it must operate within specific budget parameters.

Despite NC's decision to implement a separate CHIP rather than a Medicaid expansion, the decision was made to do outreach and enrollment of families for both Medicaid and Health Choice in a seamless process. A range of activities to enhance the enrollment has been implemented, including a simplified 2-page application form, multiple community application sites, mail-in option, training of community professional and agency staff to assist with the application process, twelve months continuous eligibility for both programs, and availability of applications in English and Spanish. In 2001, through funding from a Robert Woods Johnson Covering Kids Project, focus groups have been conducted to propose an even more family-friendly re-enrollment process. Specific messages, graphics, and re-enrollment strategies were tested. In addition, NC continues to focus on a grassroots approach to outreach for Health Choice. Each of the 100 counties, working through the co-sponsorship of local health and social services departments, was asked to form an outreach coalition. These coalitions have been very effective in crafting outreach strategies specific to the circumstances of their individual communities and target groups. In a parallel fashion, WCHS convened a state level coalition called the Health Check-Health Choice Outreach Committee, comprised of state, regional, and local

representatives from public/private agencies, health care provider organizations, and child advocates. The role of the WCHS has been to support efforts of local coalitions by providing print materials, electronic media pieces, monthly updates, consultation/technical assistance, workshops, and targeted outreach to various groups/organizations from the state level.

Due to strong interest from members of the General Assembly and among public health leadership, a Public Health Task Force was established in mid-2003 to study public health in NC and to devise an action plan to strengthen public health infrastructure, improve health outcomes, and eliminate health disparities. Membership on the Task Force is broad and includes legislators, community leaders, public health professionals from state agencies and universities, local health directors, other healthcare providers, and representatives from minority communities. The six committees of the Task Force reflect the Task Force's six focus areas: accreditation of state and local health departments; public health structure and organization; public health funding (finance); workforce development and training; improving public health planning, resources and health outcomes; and quality improvement and accountability. The Title V director was assigned to co-chair the accountability committee and many staff members from the WCHS served on the committees. The Task Force convened four public meetings, held three regional public forums, heard testimony, and reviewed research and lessons from the field during the course of their work. An interim report was released in May 2004 and the final NC Public Health Improvement Plan to guide public health efforts in the next two to three years was released on January 15, 2005. There were two sets of recommendations in the report -- Core Infrastructure, which addresses public health system needs required to deliver the ten essential public health services and Core Service Gaps, which addresses critical needs in core public health service program areas. A copy of the Final Report can be found at the following URL: http://www.ncpublichealth.com/taskforce/docs/FinalReport1.15.05.pdf.

In addition to the work of the Public Health Task Force, staff members from WCHS continue to collaborate with staff across the Department on one of the NC DHHS Secretary's priority areas, that of eliminating health disparities. Efforts to implement the action steps developed in the Call to Action January 2003 report continue. In May 2004, the Office of Minority Health released a publication entitled "Racial and Ethnic Differences in Health in North Carolina: 2004 Update" which clearly illustrates the areas of health disparities and need for improvement in health outcomes. These areas include health insurance coverage rates, sexually transmitted disease rates, and infant mortality rates. A copy of the report is available at the following URL: http://www.schs.state.nc.us/SCHS/pdf/RaceEthnicRpt.pdf. One way in which WCHS staff have collaborated is that C&Y Branch staff were able to work with department leadership to expand the goal for health parity for people with disabilities as well as for ethnic and racial minorities. This has resulted in integration of strategies for eliminating service delivery and health disparities among children, youth and adults with disabilities in the action plans submitted by DPH programs and other DHHS divisions.

During FY04, the WCHS implemented a logic model/outcomes-oriented planning process. Earlier in FY03, the Section Management Team (SMT) held a retreat and defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. At the same time, the NC DHHS decided to implement performance-based contracting using logic models as a component of performance-based management. Thus, during FY04, the SMT members were responsible for leading work groups to create logic models for each of the eleven core indicators. Both regional and central office staff contributed to the models which are in the final draft stage. Logic models are by design a work in progress that can be revised as necessary to more clearly and correctly depict causal relationships and integrate program activities. The Section plans to work within the framework of the current logic models over the next fiscal year and review and revise them as necessary in the spring of 2005. Certainly the results of the needs assessment might dictate changes to the inputs and outputs of the logic models. The WCHS Core Indicators are as follows:

1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age

3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders
11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

/2007/ Session Law 2005-276 by the NC General Assembly (NCGA) mandated the North Carolina Health Choice (NCHC) program to limit participation to eligible children ages 6 through 18 beginning January 1, 2006. This session law also mandated the Medicaid program to provide coverage for children birth through the age of five with family incomes equal to or less than 200 percent of the federal poverty level beginning January 1, 2006. As a result of this legislation, current NCHC children ages birth through five will be moved to the Medicaid Health Check (HC) program on January 1, 2006. Any Medicaid enrolled provider currently providing services to NCHC children ages birth through 5 must bill North Carolina Medicaid for dates of service beginning January 1, 2006. In addition, the NCGA capped NCHC enrollment growth to 3% every 6 months and reduced NCHC reimbursement rates to 115% of the HC fee schedule on 1/1/2006 and 100% on 7/1/2006. The NCGA also directed DHHS to move NCHC children (ages 6 through 18) into the Community Care of NC networks for case management services. WCHS worked closely with DMA to assure a smooth transition for NCHC children to Health Check. This involved drafting notices/letters to families and preparing a bulletin/list serve notices for providers to prepare for transition issues related to prior approval, hospital coverage, etc.

North Carolina received an Early Childhood Comprehensive System (ECCS) planning grant in 2003 which was followed by an implemenation grant in 2005. During the planning grant period, a plan for a comprehensive, integrated early childhood system in North Carolina supporting school readiness and building on existing efforts and initiatives was created. Seven goals were developed by a multi-agency "think tank." These goals were:
Goal #1 -- Share Accountability for an effective, comprehensive and integrated early childhood system.
Goal #2 -- Use a set of shared indicators for school readiness to evaluate success at all levels of the early childhood system.
Goal #3 -- Support efforts in NC to develop data sharing strategies among providers who serve young children and their families.
Goal #4 -- Ensure that providers in the early childhood system have the practical strategies and community relationships necessary to provide effect services to children and families.
Goal #5 -- Build a philanthropic/government partnership for early childhood health and development
Goal #6 -- Contribute to stakeholders' efforts to build broad-based support for investing in efforts to produce positive developmental outcomes.
Goal #7 -- Promote evidence-based or promising practices for all critical components of the early childhood system.

The purpose of the proposed project is to continue to work with a wide group of stakeholders to assure that all children in North Carolina are healthy and ready for school. The status of children on a set of shared indicators of school readiness provides a way to measure the magnitude of the problem in NC. The indicators also provide a mechanism to measure success over time.

The factors that create challenges to the goal of assuring that all children are healthy and ready for school are complex. Less than optimal connections among systems designed to support school readiness are one challenge. During the planning phase of the grant program, stakeholders agreed that while North Carolina had developed many of the critical components of

a comprehensive early childhood system and had well-developed systems in place to support those components, the systems were not necessarily connected in a way that would facilitate positive developmental outcomes, including school readiness, for young children.

During the first year of the implementation period, the goals included in the ECCS plan were prioritized based on the following factors:
1) the potential to enhance integration across systems;
2) stakeholder interest and commitment to working on the goal; and
3) opportunities or barriers created by related activities in North Carolina, including, the development of an Office of School Readiness in the Governor's Office; ongoing work in Support Partnerships to Assure Ready Kids (SPARK) projects in NC; the creation of a Ready Schools Task Force funded by the Kellog Foundation; the development of a Child Maltreatment Leadership Team with leadership in the Division of Public Health; the development of an Infant Toddler Early Leaning Guideline Committee; and a legislatively created Children's Services Work Group charged with addressing coordination issues among agencies serving children and families.

The Child Health Assessment and Monitoring Program (CHAMP) survey was developed in the fall of 2004 and implemented in January 2005. CHAMP is the first survey of its kind in North Carolina to measure the health characteristics of children, ages 0 to 17. Eligible children for the CHAMP survey are drawn each month from the BRFSS (Behavioral Risk Factor Surveillance System) telephone survey of adults, ages 18 and older. All adult respondents with children living in their households are invited to participate in the CHAMP survey. One child is randomly selected from the household and the adult most knowledgeable about the health of the selected child is interviewed in a follow-up survey. All questions about the selected child are answered only by the most knowledgeable adult. CHAMP surveys will be revised each year to meet the child health surveillance needs of North Carolina.

CHAMP, by collecting data for young children, will contribute to a seamless health data system for all North Carolina citizens from birth to old age. Questions on the CHAMP survey pertain to a wide variety of health-related topics, including breast feeding, early childhood development, access to health care, oral health, mental health, physical health, nutrition, physical activity, family involvement, and parent opinion on topics such as tobacco and childhood obesity. Collected annually, the CHAMP survey data will help monitor child health status and identify child health problems; will help evaluate child health programs and services; will help health professionals make evidence-based decisions, policies and plans; and will help monitor progress towards selected health targets, such as Healthy Carolinians 2010.//2007//

/2008/ DHHS strives to be in full compliance with the Americans with Disabilities Act of 1990 (ADA). The Department fully supports and adheres to the Reasonable Accommodations Policy of the NC State Office of Personnel. The purpose of this policy is to assist agency and university employers, current employees, and applicants for employment in requesting and processing reasonable accommodation requests. The overall intent of this policy is to ensure that the State of North Carolina fully complies with the ADA and maintains equal opportunity in employment for all qualified persons with disabilities. This policy also prohibits retaliation against employees. In addition, within the WCHS, the NC Office of Disability and Health (NCODH) addresses the ADA responsibilities when it conducts accessibility training and assessments with organizations such as fitness facilities, parks and recreation departments, senior centers, and medical offices, etc. During these training and assessment sessions, an action plan, with long and short term goals, is developed to help the facility improve its accessibility and ADA compliance. NCODH encourages ADA compliance, but does nothing to enforce compliance.//2008//

/2009/Governor Mike Easley appointed Dempsey E. Benton Secretary of the N.C. Department of Health and Human Services on September 5, 2007, following the departure of the former Secretary, Carmen Hooker Odom, who left to become President of the Milbank Memorial Fund, a New-York based foundation that conducts non-partisan

analysis, study and research on significant issues in health policy. Secretary Benton served as chief deputy secretary of the NC Department of Environment and Natural Resources from January 2001 until February 2007. Prior to that he served as the Raleigh city manager from 1983 to 2000, and as the city's assistant manager from 1974 to 1983. Earlier, Secretary Benton was the city manager of Elizabeth City and also held the position of finance director of Rocky Mount.//2009//

B. Agency Capacity

The Women's and Children's Health Section (WCHS) is comprised of five Branches, Children and Youth (C&Y Branch), Early Intervention (EI), Immunization, Women's Health (WHB), and Nutrition Services. The Section Management Team, which is comprised of the Chief, Business Operations Manager, and five Branch Heads, meets weekly to facilitate joint planning, to keep key staff informed of current activities and issues, and to plan short and long term strategies for addressing current issues. A similar process occurs within the Branches which are responsible for assessing and responding to the needs of its target population(s). In addition, once a month additional senior and middle managers meet as part of the Expanded Management Team to discuss issue such as management and leadership skill enhancement and cross-cutting Section issues such as local agency monitoring and data utilization.

Statutes
State statutes relevant to Title V program authority are established for several programs administered by WCHS. These statutes include:

GS130A-4.1. This statute requires the NC Department of Health and Human Services (NCDHHS) to ensure that LHDs do not reduce county appropriations for local maternal and child health services because they have received State appropriations and requires that income earned by LHDs for maternal and child health programs that are supported in whole or in part from State or federal funds received from NCDHHS must be used to further the objectives of the program that generated the income.

GS130A-124. This statute requires NCDHHS to establish and administer the statewide maternal and child health program for the delivery of preventive, diagnostic, therapeutic and habilitative health services to women of childbearing years, children and other persons who require these services. The statute also establishes how refunds received by the Children's Special Health Services Program will be administered.

GS130A-125. This statute requires NCDHHS to establish and administer a Newborn Screening Program which shall include, but not be limited to, the following: 1) development and distribution of educational materials regarding the availability and benefits of newborn screening, 2) provision of laboratory testing, 3) development of follow-up protocols to assure early treatment for identified children, and provision of genetic counseling and support services for the families of identified children, 4) provision of necessary dietary treatment products or medications for identified children as indicated and when not otherwise available, and 5) for each newborn, provision of screening in each ear for the presence of permanent hearing loss.

GS130A-127. This statute requires NCDHHS to establish and administer a perinatal health care program. The program may include, but shall not be limited to, the following: 1) prenatal health care services including education and identification of high-risk pregnancies, 2) prenatal, delivery and newborn health care provided at hospitals participating at levels of complexity, and 3) regionalized perinatal health care including a plan for effective consultation, referral and transportation among hospitals, health departments, schools and other relevant community resources for mothers and infants at high risk for mortality and morbidity.

GS130A-129-130. These statutes require NCDHHS to establish and administer a Sickle Cell Program. They require that LHD provide sickle cell syndrome testing and counseling at no cost to

persons requesting these services and that results of these tests will be shared among the LHD, the State Laboratory, and Sickle Cell Program contracting agencies which have been requested to provide sickle cell services to that person. In addition, these statutes establish the Council on Sickle Cell Syndrome, describing its role and the appointments, compensation, and term limits of the council members.

GS130A-131.8-9 These statutes establish rules regarding the reporting, examination, and testing of blood lead levels in children. Statutes 131.9A-9G include requirements regarding the following aspects of lead poisoning hazards: 1) investigation, 2) notification, 3) abatement and remediation, 4) compliance with maintenance standard, 5) certificate of evidence of compliance, 6) discrimination in financing, 7) resident responsibilities, and 8) application fees for certificates of compliance.

GS130A-131.10. This statute establishes the manner of disposition of remains of pregnancies.

GS130A-131.15. This statute requires NCDHHS to establish and administer an Adolescent Pregnancy Prevention Program. The statute describes the management and funding of the program including the application process, proposal requirements, operating standards, criteria for project selection, schedule of funding, and funding limitations and levels.

GS130A-131.16-17. These statutes establish the Birth Defects Monitoring Program within the State Center for Health Statistics. The program is required to compile, tabulate, and publish information related to the incidence and prevention of birth defects. The statutes require physicians and licensed medical facilities to permit program staff to review medical records that pertain to a diagnosed or suspected birth defect, including the records of the mother.

GS130A-131.25. This statute establishes the OWH in an effort to expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of women. The primary goals of the Office shall be the prevention of disease and improvement in the quality of life for women over their entire lifespan.

GS130A-134. This statute establishes the list of communicable diseases and communicable conditions to be reported.

GS130A-152-157. These statutes establish how immunizations are to be administered, immunization requirements for schools, child care facilities, and colleges/universities, and when and how medical and religious exemptions may be granted.

GS130A-371-374. These statutes establish the State Center for Health Statistics within NC DHHS and authorize the Center to 1)collect, maintain and analyze health data, and 2) undertake and support research, demonstrations and evaluations respecting new or improved methods for obtaining data. Requirements for data security are also found in the statutes.

GS130A-422-434. These statutes establish the Childhood Vaccine-Related Injury Compensation Program, explain the Program requirements, and establish the Child Vaccine Injury Compensation Fund.

GS130A-440-443. These statutes require health assessments for every child in this State entering kindergarten in the public schools and establish guidelines for how the assessment is to be conducted and reported. Guidelines for religious exemptions are also included.

Services For Pregnant Women

WCHS supports a statewide network of 85 LHD clinics which provide prenatal services to women in all 100 counties. These clinics have a long-standing commitment to the provision of multidisciplinary perinatal services including medical prenatal care, case management, health

education, nutrition counseling, psychosocial assessment and counseling, and postpartum services. A wide range of preventive health services are offered in virtually all of the LHDs, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and Gynecology (ACOG) guidelines. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant NC regulations and are provided in the Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. The accountability tool developed from these standards could form the kernel of an accountability system for Medicaid and commercial managed care services. Consultation and technical assistance for all contractors is available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional nursing and social work consultants who routinely work with agencies within assigned regions. In order to achieve the WCHS goal of risk-appropriate prenatal care, the Section also supports 18 high risk maternity clinics (HRMCs) across the state. The "traditional" HRMCs, located at tertiary care centers, are supervised by Maternal-Fetal Medicine specialists with immediate access to state-of-the-art technical support services and subspecialty consultation. These clinics have true regional catchment areas and function as "end providers." They are equipped to handle the highest risk prenatal clients without need for referral to higher levels of care. The remaining HRMCs are housed in larger health departments, and are generally staffed by local obstetricians. They do not draw from a regional catchment area and refer the highest risk clients to the tertiary centers for care. At the time of the inception of the HRMC program, the LHD HRMCs were pioneers in the provision of multidisciplinary care and also filled in some gaps where intermediate level care was somewhat inaccessible. As time has passed, the multidisciplinary care model they pioneered has been widely adopted, at least in the public sector, and the tertiary center network in the State has matured. The future role of these "intermediate level" HRMCs is unclear. As part of its charge to provide technical assistance and oversight to this network of clinics, WCHS continues to assess what changes are needed in the program to achieve the goal of risk-appropriate services for all pregnant women.

Maternity Care Coordination-Maternity Care Coordination (MCC) is the cornerstone of the state's attempts to eliminate barriers to prenatal care service provision. MCC services are provided by a nurse or a social worker whose primary role is to help clients access and effectively utilize services that address medical, nutritional, psychosocial and resource needs, while providing emotional support. The majority of MCCs are based in LHDs, but an increasing number are being based in private prenatal provider offices. WCHS provides start-up funding to local providers of support services to encourage them to hire additional care coordinators in order to increase the percentage of Medicaid clients who receive care coordination. WCHS also administers a limited amount of state appropriations which categorically support the provision of care coordination services to clients ineligible for Medicaid. LHDs are free to allocate portions of the block granted federal and state funds they receive to provide MCC or other support services to clients ineligible for Medicaid.

Maternal Outreach Worker Program-The Maternal Outreach Worker (MOW) program grew out of the state's experience with the MCC program. MCCs, who are trained professionals working primarily in clinic settings, had only limited time to address the social and emotional support needs of many of their clients. It was felt there was a need for community-based services provided by women with strong community roots. MOWs are paid, trained paraprofessionals who work under the supervision of an MCC and function in some respects as an MCC-extender. The MOW functions as a problem solver, assessing each client's needs and working with the client to address those needs, adopt healthy behaviors, and avoid unintended pregnancies postpartum.

Infant Mortality Reduction Programs - In 1994, the NC General Assembly appropriated $750,000 annually to fund projects that demonstrate ways to lower infant mortality and low birthweight rates among minority populations. The Minority Infant Mortality Reduction Project (MIMRP) currently supports l5 projects for an average of $50,000 per year for up to three years. These projects address the two-fold disparity in infant mortality rates between whites and non-whites through many initiatives, including education, community development and awareness, lay health advisors, and other outreach efforts. MIMRP was conceived as primarily a demonstration project, so the numbers of persons served by the program may not be great enough to impact statewide performance measures. The MIMRP is a joint initiative of WCHS, the Office of Minority Health and the Healthy Start Foundation.

The Targeted Infant Mortality Reduction (TIMR) program was established by the General Assembly in 1989 to provide funding that would improve the perinatal care systems in high "attributable risk" counties in the state (i.e., counties with high numbers and rates of infant mortality). Although recipient counties have substantial flexibility in the use of these funds, most of the $306,000 annual appropriation is used to support enabling services. Counties have expanded outreach efforts in maternity and family planning clinics, provided transportation and child care services for clients, and provided enhanced follow-up of persons with positive pregnancy tests and missed prenatal care appointments.

During FY98, the WCHS received the first year of funding for the federal Healthy Start grant, Eastern Healthy Start Baby Love Plus (HSBLP). The goals of this project are to reduce infant morbidity and mortality in the seven county project area in eastern NC by incorporating three models to: support and empower a community-based consortium; provide outreach and case finding services; and to provide facilitating services which will reduce barriers to accessing services. community-based organizations to also develop local programming to address infant mortality and morbidity in their community. Funding for the Eastern HSBLP project continued in FY00 and funding for an additional Healthy Start initiative, the Triad HSBLP project, began. The Triad HSBLP project focuses on the racial/ethnic disparities in perinatal health in two of the state's more urban counties, Forsyth and Guilford. The four funded models being implemented are community-based consortium, case management, enhanced clinical, and outreach/client recruitment. Also funded in FY00 was a planning grant for the Northeastern (NE) HSBLP program. This grant resulted in FY01 funding for a Healthy Start initiative in five rural, underserved counties in northeastern NC. Its focus is to improve African-American perinatal health primarily and Native American/American Indian perinatal health secondly. As of May 2005, the WHB is waiting to hear whether the Triad site has be re-funded for another grant cycle. The NE site will begin year 2 of 4 in round two on June 1, 2005. The Eastern site is in its 4th year of a 4 year cycle - round two. It is slated to end on January 31, 2006, with a new competitive grant application due sometime in August 2005.

/2007/Pending availability of federal funding, the three Health Start Baby Love Plus projects continue. The Eastern Baby Love Plus project was awarded a new four year grant that began February 1, 2006 and will run until January 31, 2010. The Northeastern site is funded until May 2008 and the Triad site until May 2009.//2007//

Child Health Services

WCHS provides preventive health services to children from birth to 21 years of age primarily through LHD clinics. The schedule of recommended visits is based on Bright Futures guidelines. Normally, clinic services are not provided for acutely ill children, although some health departments do provide pediatric primary care. Nurse screening clinics are conducted by public health nurses in LHDs. Physicians do not staff these clinics; however, services are provided under the guidance of the physician who attends the pediatric supervisory clinic. Medical management includes written policies and procedures that are updated regularly. Public Health Nurse Screeners receive specialized training for this role through a training program sponsored by the C&Y Branch. Nurse screening clinic services include: parental counseling regarding good

health, nutrition practices and developmental milestones; immunizations; assessment of proper growth, development, hearing, vision, and speech; screening for anemia and lead; and referrals as needed. Pediatric clinics are conducted by physicians (family practitioners and/or pediatricians), nurse practitioners, and/or physician assistants. They serve as referral clinics for children with problems identified in nurse screening clinics. Pediatric clinic staff make referral for specialty consultations as needed.

The purpose of the Health Check program is to facilitate regular preventive medical care and the diagnosis and treatment of any health problem found during a screening for children eligible for Medicaid and under the age of 21. Health Check Coordinators (HCC) play a vital role in outreach efforts and assuring that Medicaid recipients access preventive health screenings. The HCC use an Automated Information and Notification System (AINS) to track and follow Medicaid eligible children. This system has the ability to generate personalized reminder and missed appointment letters based on paid claims data. The HCC make direct contact with clients via telephone calls, additional personalized letters, and occasional home visits. The type and results of their contacts are recorded in the comment section of the database. They work closely with the managed care representatives at local departments of social services to ensure children are connected with their primary care provider for continuity of care. In addition, they work closely with the provider community to ensure children receive regular preventive health care and follow-up for conditions that have been referred to a specialist.

NC Health Choice for Children, the child health insurance program in NC, is a federal and state partnership to provide comprehensive health insurance to uninsured children. It provides free or low cost health insurance to children whose families cannot pay for private insurance and who do not qualify for Health Check. Children with special health care needs are eligible to receive additional benefits under NC Health Choice. This program is administered jointly by DMA and DPH, with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. Outreach to potentially eligible families is coordinated by Outreach Coalitions in each county. WCHS supports the efforts of the local coalitions by providing tools such as print materials, electronic media pieces, monthly coalition updates, consultation and technical assistance, workshops, and outreach to state and regional organizations.

School Health Matrix Team (SHMT) - The SHMT was created in FY04 in order to formalize a system by which all DPH staff working to improve the health status of students will be able to work together to develop unified plans and activities to work with students and schools. It is hoped that this streamlined effort will maximize the Division's school health resources and more efficiently meet the students' health needs. Membership of the SHMT is made up of DPH staff whose key work responsibilities involve working with schools. This structure brings together four DPH Sections and nine Branches and Units. One direct impact of this new structure is the change in the role of the state public health dental hygienists, who will be cross-trained on a broad range of school health topics and will be collaborating with local school nurses and other school health professionals. The SHMT works in a framework based upon the Centers for Disease Control and Prevention (CDC) eight component model of school health, also referred to as a Coordinated School Health Program. The SHMT will collaborate closely with the Department of Public Instruction (DPI), with the Senior Advisor for Healthy Schools serving as a member of the SHMT.

During FY04, the C&Y Branch worked with the NC Pediatric Society, the state Medicaid agency, LHDs and other partners to institute changes in procedures for developmental screening for all children. The following procedures were implemented for LHDs in July 2004:
- WCHS adopted the July 2001 statement of the American Academy of Pediatrics on Developmental Screening which includes specific instruments and periodic schedules that are recommended for evidence-based, formal developmental screening of children. Where there is concern about developmental status due to screening results or parental/provider concern, the child would be followed through second level screening or, if indicated, referred as soon as possible for in-depth testing/evaluation.

- Children should be screened with a formal, standardized developmental screening instrument at a minimum of 6, 12, and 18 to 24 months and 3, 4, and 5 years of age at well child visits.

The Specialized Services Unit worked with a logic model planning process to develop the following intermediate outcomes related to developmental screening:
Children will be screened early and continuously for special health care needs as measured by:
- % of infants whose mothers began prenatal screening in the first trimester
- % of infants and families monitored for special health care needs and developmental delays
- % of children receiving age appropriate well-child checks
- % of children receiving follow-up due to failed screening (vision, hearing, developmental, behavioral, mental health, oral health, metabolic)

Effective July 2004, DMA will implement policy requiring physicians who perform EPSDT well-child check-ups to use standardized assessment tools to perform developmental screening. These changes will also require the entry of a separate current procedural terminology (CPT) code to indicate that the screen was conducted.

Another major focus area for the C&Y Branch has been to build the capacity of primary care providers to provide quality preventive mental health services to children and families. Plans include offering training to practices on ways to incorporate behavioral health screening and appropriate interventions as part of their core service provision. Specific steps include:
-Work with existing communities that have developed successful models for information dissemination;
-Provide intensive work with individual practices to successfully integrate behavioral health services into their workflow;
-Coordinate collaborative calls among providers for information exchange on successful intervention strategies;
-Identify quality improvement teams from model practices to meet regularly to discuss issues identified within practices, develop possible solutions, and disseminate that information to practices involved in performance improvement;
-Develop and disseminate referral network information to providers specific to their community; and
-Educate referral resources on the need to provide feedback information to the referring physician.

Services for Children with Special Health Care Needs (CSHCN)

Children's Special Health Services (CSHS) is a state-administered program, financed by both federal and state funds. Care is provided through a network of professionals in the private section, clinics, hospitals, schools, and community agencies. All aspects of patient care are addressed, including assessment, treatment, and follow-up. CSHS provides cardiology, neurology, neuromuscular, oral-facial, orthopedic, myelodysplasia, speech/language and hearing services. In addition to providing diagnostic and treatment services through CSHS-sponsored clinics, the program also reimburses limited services for eligible children on a fee-for-service basis. Covered services include hospitalization, surgery, physicians' care, laboratory tests, physical, occupational and speech therapy, medication, durable medical equipment, orthotics and prosthetics, medical supplies and other interventions. In addition to specialty clinic services, selected "wrap-around" services are funded for Medicaid-eligible children on a fee-for-service basis. CSHS is reimbursed by Medicaid for provision of most of these services, which include hospitalization; physicians' care; laboratory tests; physical, occupational and speech therapy; medication; durable medical equipment; orthotics and prosthetics; medical supplies; and other interventions.

FY03 was a year of deep reflection and change for the CSHCN program. The WCHS continues to be committed and guided by the key principles of comprehensive, community based, coordinated

and family-centered care. There have been dramatic changes at the state and community level among key collaborators such as Early Intervention, Mental Health/Substance Abuse/Developmental Disability, School Health, and the private and public health care financing and delivery system, as well as significant shifts in priorities and resource allocation in DPH. In response, the CSHCN program has continued to review and critically evaluate all aspects of the program. The process has been directed by key personnel within CSHCN, in conjunction with a strengthened Family Advisory Council, the Commission for Children with Special Health Care Needs, and other representatives from key constituency groups. Driven by considerations to improve the efficiency and effectiveness of services, while concurrently developing strategies reflective of a family-centered approach, the CSHCN program is being reorganized both centrally and regionally in WCHS, as well as in relation to community partners. The early evidence is that this will result in improved collaboration and coordination. Of equal importance, the objective to better integrate services and supports for children with special health care needs into all aspects of C&Y Branch initiatives is being strongly pursued.

Child Service Coordination-The purpose of the Child Service Coordination (CSC) program is to identify and provide access to preventive and specialized support services for children and their families through collaboration. Children are eligible for the CSC program if they are at risk for, or have a diagnosis of developmental delay or disability, chronic illness, or social/emotional disorder. In the CSC program, a service plan for the child/family is developed based on an assessment of the families identified strengths, needs and concerns. Coordinators work with other health and social services providers to monitor the child's development, strengthen parent-child interactions, foster family self-sufficiency, provide information about available programs and services, assist with application forms, and/or help to locate desired and appropriate resources. Follow-up contacts are required at least monthly; however, the frequency is actually based on family ability and need. Children from birth to age three who meet one of the definitions of the program Risk Indicators and children from birth to five who meet one of the definitions of the program Diagnosed Conditions are eligible. There are no income eligibility requirements for the CSC Program.

Newborn Screening Services - Universal newborn screening services have been available in NC since 1966. In 1991, provision of such services became a legislative mandate with the passage of House Bill 890 "An Act to Establish a Newborn Screening Program Within the Department of Environment, Health and Natural Resources." The State Public Health Laboratory screens all newborns born in NC for phenylketonuria (PKU), congenital hypothyroidism (CH), galactosemia, congenital adrenal hyperplasia (CAH), and hemoglobinopathy disease (e.g., sickle cell). Beginning in July 1997, screening for an array of metabolic disorders using tandem mass spectrometry technology was instituted. Timely follow-up is provided by the Genetic Health Care Newborn Screening Program on all infants with suspicious laboratory results.

Neonatal Hearing Screening - Hearing screening has been mandatory for all infants born in NC as of October 1, 1999. Screening equipment was provided to 60 birthing hospitals through a special project of WCHS. The tests are performed quickly while babies are asleep. Audiologists affiliated with C&Y Branch Speech and Hearing Teams provide technical assistance to the hospitals and also perform infant hearing screenings and diagnostic assessments for older children.

/2007/The School Based Child and Family Support Team Initiative was begun during FY06. Its mission is to provide appropriate family-centered, strengths-based community services and supports to those children at risk of school failure or out-of-home placements as a result of the physical, social, legal, emotional, and developmental factors that affect their academic performance. While the staff person for the Initiative reports directly to the Secretary of DHHS, he is housed in the C&Y Branch and collaborates with branch members on this project. Through the Initiative, all State and local child serving agencies will collaborate and communicate to share responsibility and accountability to improve outcomes for at-risk children and their families. In 100 schools located in 21 Local Education Agencies across the State, Child and Family Support

Team Leaders (a school nurse and social worker team in each school) will identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect their academic performance. These services are necessary so that those at-risk children may succeed academically, live in safe, nurturing and permanent families, and have opportunities for healthier and more stable lives.//2007//

/2008/The Minority Infant Mortality Reduction Project name was changed to Healthy Beginnings.//2008//

C. Organizational Structure

The NC Title V program is housed within the NC Department of Health and Human Services (DHHS) in the Division of Public Health (DPH). DHHS is a cabinet-level agency created in October 1997 when the health divisions of the Department of Environment, Health and Natural Resources (DEHNR) were combined with the existing Department of Human Resources (DHR). Carmen Hooker Odom was appointed as Secretary of the Department of Health and Human Services (DHHS) by the Governor, Mike Easley, in February 2001. Serving as State Health Director and Division Director for DPH is Dr. Leah Devlin.

The Department is divided into 24 divisions and offices which fall under four broad service areas - administrative, support, health, and human services. Divisions include: Aging; Budget, Planning, and Analysis; Child Development; Facility Services; Human Resources; Information Resource Management; Medical Assistance; Mental Health, Developmental Disabilities, and Substance Abuse Services; Public Health, Services for the Blind; Services for the Deaf and Hard of Hearing; Social Services; and Vocational Rehabilitation. The Department is also responsible for managing the town of Butner.

Offices include: Department Controller; Council on Development Disabilities; Economic Opportunity; Education Services; Internal Auditor; Legal Affairs; Property and Construction; Public Affairs; and Research, Demonstrations, and Rural Health Development. DHHS also oversees 18 facilities: Western N.C. School for the Deaf, Morganton; Eastern N.C. School for the Deaf, Wilson; Governor Morehead School for the Blind, Raleigh; Whitaker School, Butner; Wright School, Durham; Broughton Hospital, Morganton; Cherry Hospital, Goldsboro; Dorothea Dix Hospital, Raleigh; John Umstead Hospital, Butner; N.C. Special Care Center, Wilson; Alcohol and Drug Abuse Treatment Center (ADATC)-Black Mountain; ADATC-Butner; Walter B. Jones ADATC-Greenville; Black Mountain Center, Black Mountain; Caswell Center, Kinston; Murdoch Center, Butner; O'Berry Center, Goldsboro; and Western Carolina Center, Morganton.

The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of NC individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

DPH is comprised of the Director's Office and six Sections. The Director's Office houses units with Division-wide impact, including:
- DPH Personnel Office (staffed by DHHS Division of Human Resources)
- Office of Chief Medical Examiner
- State Center for Health Statistics
- State Laboratory
- Vital Records

Other programs and services are operated out of the five Sections: Administrative, Local and Community Support; Chronic Disease and Injury; Epidemiology; Oral Health; and Women's and Children's Health.

The WCHS is responsible for overseeing the administration of the programs carried out with allotments under Title V. Kevin Ryan, Section Chief, is the Title V Program Director and Carol Tant, Children and Youth Branch Head, is the CSHCN Program Director. The mission of WCHS is to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth. WCHS programs place a major emphasis on the provision of preventive health services beginning in the pre-pregnancy period and extending throughout childhood. The Section also administers several programs serving individuals who are developmentally disabled or chronically ill. As mentioned previously, WCHS is comprised of five Branches: Children & Youth, Early Intervention, Immunization, Nutrition Services, and Women's Health.

The public health system in NC is not state administered, but there are general statutes in place for assuring that a wide array of maternal and child health programs and services are available and accessible to NC residents. Using federal Title V funds and other funding sources, WCHS must contract with local health departments (LHDs) and other community agencies to assure that these services are available. There are 85 local health department clinics which provide clinic and preventive services in all 100 counties. In addition, there are many community health centers and other agencies providing services. Each contract contains a scope of work or agreement addenda that specifies the standards of the services to be provided. The public health departments, which have local autonomy, have a long-standing commitment to the provision of multidisciplinary perinatal, child health, and family planning services, including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, postpartum services, child service coordination, well-child care, and primary care services for children.

A wide range of preventive health services are offered in virtually all of these health departments, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and Gynecology (ACOG) guidelines. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant NC regulations and are provided in soon to be published Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. Local health agencies receiving Title X funding to provide family planning services must abide by the January 2001 Program Guidelines for Project Grants for Family Planning Services developed by the Office of Population Affairs (OPA), US Department of Health and Human Services.

Consultation and technical assistance for all contractors are available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional child health and women's health nursing and social work consultants who routinely work with agencies within assigned regions.

In 2004, the state piloted a new program, the NC Local Public Health Accreditation Program (NCLPHAP). This program seeks to assure and enhance the quality of local public health in NC by identifying and promoting the implementation of public health standards for local public health departments, and evaluating and accrediting local health departments on their ability to meet these standards. In the first year, 6 local health departments volunteered to undergo the accreditation process as a pilot, and in 2005, four more will be evaluated. The goal of the NCLPHAP is to assure the capacity of every local public health agency in NC to perform a standard, basic level of service. The NCLPHAP does not create an entirely new accountability system; rather it links basic standards to current state statutes and administrative code and the many DPH and Division of Environmental Health (DEH) contractual and program monitoring

requirements that already exist. The Division's goal is to see that instead of a voluntary process of accreditation, the NCLPHAP becomes a mandated procedure.

Organizational charts for DHHS and DPH are attached.
An attachment is included in this section.

D. Other MCH Capacity

The Section employs over 600 staff members responsible for management and administration of programs and services for the MCH population.

Key staff members

Section Chief - Dr. Kevin Ryan replaced Dr. Ann Wolfe as Title V Director in March, 1999. He had served as Chief of the Women's Health Section (now Women's Health Branch) since 1991. Dr. Ryan graduated from the University of California at Davis Medical School and completed a residency in Obstetrics and Gynecology at the University of Arizona Health Sciences Center in Tucson, Arizona. After completing his residency in 1986, he became an Assistant Professor in the Department of Obstetrics and Gynecology and then began a private practice in obstetrics and gynecology. He completed an M.P.H. from the UNC School of Public Health, Department of Maternal and Child Health in 1991. Since his graduation he has maintained an active relationship with the Department, and has served as Adjunct Assistant and then Associate Professor.

Section Business Operations Manager - Peter Andersen assumed this position in March 2001. Mr. Andersen has a master's degree in Health Education from the University of Virginia (1976) and a Master of Business Administration from Delaware State University (1989). He has been in the public health field for 19 years. The first eleven were with the Delaware Division of Public Health in a variety of chronic disease program management positions. His eight years with the North Carolina state health agency have been in positions in health promotion and chronic disease prevention.

Women's Health Branch Head - Dr. Joe Holliday replaced Dr. Kevin Ryan as Women's Health Branch Head in February 2000. Dr. Holliday has over 25 years of public health leadership experience, including local health director positions in Virginia, South Carolina and North Carolina. Previous Division of Public Health duties included: program manager for the Comprehensive Breast and Cervical Cancer Control and Wise Woman Programs; and Chief of the Chronic Disease Prevention and Control Branch. He is a graduate of University of North Carolina at Chapel Hill, Vanderbilt School of Medicine, and the UNC School of Public Health (Department of Maternal and Child Health). He also completed a pediatric internship from Pittsburgh Children's Hospital and a preventive medicine residency from the School of Medicine, University of North Carolina.

Children and Youth Branch Head - Carol Tant replaced Tom Vitaglione as Branch Head in February 2000. She has an undergraduate degree in psychology, and earned her M.P.H. in health administration from the UNC School of Public Health in 1980. She worked in increasingly responsible positions in mental health, women's health and children's health services. Carol's work experience in children's health for over 19 years has included positions in genetics, specialized services and preventive health at both the regional and state levels.

Nutrition Services Branch Head - Alice Lenihan earned a B.S. in food and nutrition from the College of St. Elizabeth (New Jersey, 1970), and a M.P.H. in health administration from the UNC School of Public Health in 1983. After gaining local and regional experience in WIC programs, she was appointed state WIC Director in 1984. She continues to serve in that capacity as Nutrition Services Branch Head. In addition to the WIC program, she has oversight of the state's Child and Adult Care Feeding Program, Summer Food Service Program, and Nutrition Education and Training Program.

Immunization Branch Head - Beth Rowe-West assumed the position of Branch Head in December 1999 after serving in an acting capacity since October, 1998. She earned her B.S. in Nursing from the University of North Carolina at Greensboro and has worked most of her career in public health, serving 11 years in a local health department prior to coming to the Immunization Branch as the Hepatitis B Coordinator in 1994.

Early Intervention Branch Head - Deborah Carroll assumed the position of Branch Head in March 2005. She received a BS in Speech Pathology from Appalachian State University, a MA in Speech Pathology-Audiology from UNC Greensboro and a PhD in Human Development and Family Studies from UNC Greensboro. She is licensed and board certified in Audiology. She worked from 1999 to 2003 in the EI Branch as Director of EI's Comprehensive System of Personnel Development. Most recently she was the Unit Manager of the Genetics and Newborn Screening Unit of the C&Y Branch of the WCHS.

Data Specialist/Needs Assessment Coordinator (State Systems Development Initiative Project Coordinator) - Sarah McCracken Cobb began working in this position on July 1, 2000. She completed her undergraduate degree in chemistry at the University of North Carolina at Chapel Hill in 1987 and earned an MPH from Boston University in 1989. After serving in the US Peace Corps, she has held assessment positions with the state health agency in HIV/AIDS, immunization, and maternal health programs.

During FY04, the C&Y Branch filled the Family Liaison Specialist position by a family member of an adolescent with special needs, Marlyn Wells. She serves as staff to the Family Advisory Council, which works extensively with the staff of the C&Y Branch. She trains, assists and advises staff on the development and promotion of family related issues and activities such as family perspectives, family centered care, care coordination, transition planning, medical home and educational/community resources. She also advises WCHS families on an as-needed basis on issues related to children with special needs.

/2007/Gerri Mattson, MD,MSPH joined the Women's and Children's Health Section in August 2005. She received her MD from the Medical College of Virginia in 1993, completed her internship and residency at Emory University in 1996, and received her MSPH from the School of Public Health at UNC in 2004. She currently serves as the Pediatric Medical Consultant for the Children and Youth Branch, but is available to the other Branches in the WCH Section. Her expertise is available to a wide range of public and private providers on best and promising practices in policy, program development, and evaluation related to child and adolescent health. She has almost thirteen years of experience in a variety of pediatric health care and public health settings.//2007//

E. State Agency Coordination

With creation of the Department of Health and Human Services in October 1997, state-level public health, mental health, social services, Medicaid, child welfare, vocational rehabilitation, substance abuse, and child development programs are now administered from a single agency. The DHHS Secretary has weekly meetings of the directors of these programs. These serve as a forum for discussing common issues and for facilitating coordination of efforts. The DHHS Assistant Secretary for Health conducts regular meetings with the directors of the three divisions that he manages (Public Health; Facility Services; and Mental Health, Developmental Disabilities, and Substance Abuse Prevention) Thus, intra-agency coordination is expected and facilitated at all levels of the organization. In addition, the Division is signatory to formal written agreements with several agencies, including:

-DHHS Division of Medical Assistance for provision of Medicaid reimbursed services for the MCH population. The current agreement includes a wide array of services and defines joint responsibility for informing parents and providers of the availability of MCH and Medicaid services. This agreement is revised in its entirety every five years, with interim changes as

needed.
-Department of Public Instruction (state education agency) for assuring the provision of multidisciplinary evaluation, special therapies, health and medical services, and service coordination. This agreement is updated every three years and meets the requirements of the Individuals with Disabilities Act (PL 102-119).
-DHHS Office of Research, Demonstrations and Rural Health Development (formerly Office of Rural Health and Resource Development). The state primary care agreement outlines the Division's relationships with community health centers and other primary care providers.
-DHHS Division of Vocational Rehabilitation Under this agreement, the Division assumes responsibility for informing families of the availability of SSI, eligibility determination (when appropriate) and assurance that children remain under care.
-DHHS Division of Child Development This agreement specifies collaboration in three areas: child care health and safety training calendar; a monthly family child care health bulletin; and support for the child care health specialist position that responds to health and safety issues through the 1-800-CHOOSE1 hotline. The hotline gives access to the resource center which provides training, technical assistance and information to child care health consultants, child care providers, and consumers. WCHS also is an active member of the Advisory Committee on Public Health Issues and Child Care.

WCHS staff assure that information about health and social services is available to the target population by supporting the following toll-free information and referral hotlines:
-Family Support Network (1-800-TLC-0042) provides information about special health problems and the availability of services for children with special health care needs. (Meets IDEA requirements.)
-CARELINE (1-800-662-7030) provides general information about available social services.
-NC Family Health Resource Line (1-800-367-2229) provides information, advocacy and referrals for primary and preventive health services for children and youth and provides general perinatal information with special emphasis on reaching pre-conceptional and pregnant women. (Database linked to CARELINE.)
-CSHCN Help Line (1-800-737-3028) provides information about genetic services and services for children with special health care needs.

Division of Public Health and WCHS staff work with the state education agency (Department of Public Instruction) on a number of projects including a CDC-funded grant to improve interagency coordination of health services offered by health and education agencies (CDC "infrastructure" grant), and nutrition programs. In addition, WCHS provides leadership, consultation and technical assistance to the state education agency and local school districts for:
-Development and maintenance of school-based and/or school-linked health centers,
-Expansion and enhancement of school nurse services,
-Nutrition and related training for food service workers, and
-Implementation of USDA-funded summer food and nutrition programs.

Close working relationships are maintained with the UNC School of Public Health, particularly with its Department of Maternal and Child Health. Division staff members serve as adjunct faculty members and are frequent lecturers in the Department, in addition to serving on Departmental advisory committees. Faculty members are asked to participate in Division planning activities to provide review and critique from an academic and practice perspective.

Although local health departments operate as autonomous entities, the state health agency funds a substantial amount of their services and the Division of Public Health works closely with them in all phases of program development, implementation and evaluation.

Strong relationships between state and local agencies are maintained by the continuous efforts of WCHS staff members to involve these agencies in the development, implementation and evaluation of WCHS initiatives. WCHS staff lead or participate in state-local collaborations that include, but are not limited to the following task force, on-going, or ad hoc working groups:

-Medicaid Outreach and Education
-Health Check Initiative
-Child Fatality Task Force
-Council on Developmental Disabilities
-IDEA Interagency Coordinating Council
-Smart Start Partnership for Children (Governor's early childhood initiative)
-Coalition for Healthy Youth
-Family Preservation / Family Support Initiative
-Healthy Child Care North Carolina
-Baby Love Program (enhanced services for pregnant women and infants)
-First Step Campaign (infant mortality reduction)
-Early Intervention Intra-agency Work Group
-WCHS/Medicaid Intra-agency Work Group

Adding to the success of these efforts is the strong involvement and participation of professional agencies in Division activities. The Division works closely with the medical societies (pediatric, obstetric/gynecologic, and family practice). The Division also maintains close working relationships with other advocacy and non-profit agencies that include the NC Partnership for Children, Prevent Child Abuse NC, and the NC March of Dimes.

/2007/ The name of the "Special Needs Helpline" was changed to the "Children with Special Health Care Needs Helpline (CSHCN Helpline)." This toll-free helpline continued to be the focal point for information on state and local programs and resources for CSHCN. Approximately 3,000 callers/year access the help line, which serves as the division's primary resource for families of CSHCN wanting information on multiple public programs with one call. For the majority of callers, health insurance issues were central to the conversation. Information shared by callers is compiled and reported to the Commission on CSHCN six times per year. The data are useful for program development purposes in terms of capturing trends of unmet needs reported by parents and providers of CSHCN. Through collaboration with the Title V Help Line (NC Family Resource Line) for translation services agreed upon in FY06, capacity for the CSHCN Help Line to adequately assist callers who speak Spanish only has been increased.//2007//

/2009/The Community Care of North Carolina (CCNC) program is building community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services. By establishing regional networks, the program is establishing the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.

The program office is based in Raleigh at the North Carolina Office of Rural Health and Community Care. The program office is sponsored by the Office of the Secretary, the Division of Medical Assistance, and the North Carolina Foundation for Advanced Health Programs, Inc. Additional grant funding has been obtained for start-up and for pilot demonstrations from Kate B. Reynolds Health Care Trust, the Commonwealth Fund, and the Center for Healthcare Strategies. The North Carolina Foundation for Advanced Health Programs, Inc. is a private non-profit organization that also serves to provide staffing and grant funding opportunities.//2009//

F. Health Systems Capacity Indicators

Introduction

/2009/ Data are available for all of the Health System Capacity Indicators through a variety of sources, but primarily through the State Center for Health Statistics (SCHS) from birth files, hospital discharge records, Medicaid records, linked/matched datasets, and various surveillance systems.//2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	75.4	76.2	61.5	62.7	58.1
Numerator	4295	4385	3554	3651	3433
Denominator	569623	575492	577894	582302	590582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Notes - 2006
Data are for the prior CY, e.g., FY06 is really CY05 data.

Notes - 2005
Data are for the prior CY, e.g., FY04 is really CY03 data.

Narrative:
/2008/Hospital discharge data for 2005 indicate a hospitalization rate due to asthma of 62.7 children per 10,000 less than 5 years of age. These data are similar to the 2004 rate of 61.5 per 10,000, but trend data are still very erratic. 2006 CHAMP data on the prevalence of current asthma in children less than 5 years old in NC are not available at this time for comparison.

In the spring of 2007, the NC Asthma Program was pleased to release "The North Carolina State Asthma Plan, 2007-2012" and also NC's first comprehensive asthma surveillance report, "The Burden of Asthma in North Carolina, 2006." Copies of each of these reports can be found at the following URL: http://www.asthma.ncdhhs.gov/.//2008//

/2009/Hospital discharge data for 2006 show a slight decline in the hospitalization rate for children less than 5 years of age (58.1 hospitalizations per 10,000 children) as compared to 2005 data (62.7 per 10,000). Prevalence data of the percent of children under age 5 with current asthma from the Child Health Assessment Monitoring Program (CHAMP) survey conducted in 2006 showed a slight decline from 2005 data as well (10.5% of children in 2005 and 10.3% in 2006).//2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	89.8	90.2	90.8	91.2	92.1
Numerator	87821	90905	95718	101575	107453
Denominator	97798	100806	105384	111411	116718
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Prior to FY99, calendar year data are reported, but beginning with FY00, state fiscal year data (July-June) are reported. These data are taken from the HMLR5501 SFY report.

Narrative:
/2008/The percentage of infants receiving periodic screenings through Medicaid continued to increase in FY06 with the rate being 91.2%. As of January 1, 2006, children age 0 to 5 in North Carolina whose family income is <200% of poverty are eligible for Medicaid. Thus, some infants previously covered by the North Carolina Health Choice for Children program (NC's SCHIP program) are now being covered by Medicaid. This policy change probably accounts for some of the increase in the denominator for this measure (from 105,384 in FY05 to 111,411 in FY06, an almost 6% increase).//2008//

/2009/Particpation rates continued to increase slightly as the rate for FY07 was 92.1%. The change in Medicaid eligibility criteria mentioned above continues to impact these numbers, with the denominator increasing by more than 5000 children between FY06 and FY07. The C&Y Branch staff members continue work on various outreach efforts to increase the number of children with health insurance and to emphasize the importance of having a medical home which also impact the percentage of infants receiving a periodic screen.//2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	75.5	79.0	74.3	71.8	
Numerator	77	83	104	89	
Denominator	102	105	140	124	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
As of January 1, 2006, children age 0 to 5 in North Carolina whose family income is <200% of poverty are eligible for Medicaid, so data on all infants is included in HSCI#02.

Notes - 2006
These data are for CY2005. As of January 1, 2006, children age 0 to 5 in North Carolina whose family income is <200% of poverty are eligible for Medicaid, so data on all infants will be included in HSCI#02 in future applications.

Notes - 2005

Data are for prior Calendar Year, e.g., FY02 is really CY01 data. Data prior to CY00 are not available. There was a freeze on Health Choice (name of NC's SCHIP) enrollment January 2001 through October 2001, thus the total number of enrollees dropped from previous years. Also, the total number of enrollees is small to begin with because Health Choice only covers the infants between 185% of poverty up to 200% of poverty. Below 185%, infants are eligible for Medicaid.

Narrative:
/2008/As noted previously, in 2005 the NC General Assembly changed the NC Health Choice for Children (NCHC) program to cover only children between the ages of 6 through 18 effective January 1, 2006, moving eligible children birth to five to the Medicaid program. Thus, the data reported for this measure for CY05 will be the final data reported. As the average number of infants in the NCHC program has been about 100 for each of the four full years of the program, fluctuations in the percent of children receiving periodic screenings is anticipated; however the four year rate (CY02 to CY05) of 74.9% is low and shows much room for improvement.//2008//

/2009/As noted previously, NC's State Child Health Insurance Program, NC Health Choice for Children, no longer covers children ages 5 and under, as these children are all eligible for Medicaid. Please refer to HSCI 02 for information on these infants. Findings in this indicator before and after this change in eligibility are not directly comparable.//2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	87.8	87.5	87.8	86.7	85.6
Numerator	102683	103236	104833	106360	108935
Denominator	116907	117935	119378	122642	127265
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data are for previous CY (i.e., FY07 is really CY06).

Notes - 2006
Data are for previous CY (i.e., FY06 is really CY05).

Notes - 2005
Data are for previous CY (i.e., FY05 is really CY04).

Narrative:
/2008/Data for 2005 for this indicator continue to show a slight decline in the number of women receiving adequate prenatal care, although the percentage remains high at 86.7.

During FY07, the Baby Love Case Management program provided services to approximately 32% of the Medicaid population. This included ensuring early and continuous prenatal care and

reducing barriers for service delivery. The program also developed a new in-take screening form and revised the Pregnancy Outcome Summary report. This information will be used to capture data and information on client's needs along with follow-up review to determine if the needs were addressed. Documentation will also be collected to determine rationale for needs not being met.//2008//

/2009/Data for 2006 for this indicator show that the percentage remains high at 85.6%, although this is a bit of a decline from the 2005 percentage of 86.7. Refer to the narrative for NPM#18 (Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester) for a description of activities undertaken to keep increasing this percentage.//2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	86.8	87.4	87.8	88.3	88.6
Numerator	727653	766054	796361	854341	881005
Denominator	837949	876866	906853	968025	994403
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Notes - 2006
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Notes - 2005
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Narrative:
/2008/Since the change in methodology for determining data for this indicator occurred in FY02, the data for this indicator continue to increase, albeit slowly. In FY06, 88.3% of Medicaid-eligible children had received a service paid by the Medicaid program.//2008//

/2009/The percentage of Medicaid-eligible children receiving a service paid by the Medicaid program in FY07 remained high at 88.6%. Outreach efforts by C&Y Branch staff and LHD staff help maintain this percentage, as well as efforts to increase the number of children who have a medical home.//2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	34.6	35.7	37.9	39.9	42.1
Numerator	60682	64550	71513	83846	91877
Denominator	175393	180858	188464	210216	218377
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data are for previous CY (i.e., FY07 is really CY06).

Notes - 2006
Data are for previous CY (i.e., FY06 is really CY05).

Notes - 2005
Data from CY00 on have been revised to include just those children receiving Medicaid and not those under the state SCHIP (Health Choice) plan. Thus, the data for FY99 and FY00 should not be compared to the rest of the data. The FY data are actually for the prior CY.

Narrative:
/2008/2005 data for this indicator show a continued slow but steady increase in the percent of EPSDT eligible children receiving dental services, but at 39.9%, there still remains a lot of room for improvement in this area. Increasing Medicaid reimbursement rates would help improve access to dental care, but other barriers remain.//2008//

/2009/Data for this indicator show a slight increase to 42.1% of eligible children receiving dental services; however, access to dental care continues to be a major issue for many children. In FY08, there was a small increase in Medicaid reimbursement rates as the NC Legislature appropriated three million dollars which was put towards increasing rates for some codes that were the most out of line with market reimbursement rates. DMA requested and received an additional $5 million from the legislature for FY09 to increase reimbursement rates by 5%.//2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	100	100	100.0	100.0	100.0
Numerator			31303	32485	33702
Denominator			31303	32485	33702
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data Source: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Data are as of December 2007.

New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Notes - 2006
Data Source: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data.

New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Notes - 2005
Data Source: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Data are as of December 2005.

New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Narrative:
//2008//While the overall percentage for this indicator remains at 100%, the numerator and denominator have been updated to reflect the actual number of children less than 16 years old in NC receiving SSI payments (32,485 in as of December 2006 per the Social Security Administration). The referral system for newly eligible SSI children to receive needed care remains in place. Each month, WCHS receives approximately 325 referrals of newly eligible SSI children. Those children under age five are referred to Child Service Coordinators who provide the family with information about available resources, including early intervention and Title V services. Children ages 5 to 18 receive a letter describing state CSHCN services. Those children age five and older who qualify for Title V services not covered by Medicaid can receive durable medical equipment, wheelchair ramps, over the counter medications and oral formulas. A SSI Recipient Database now in place allows for better data compilation on SSI recipient children throughout the state. //2008//

/2009/The referral system for newly eligible SSI children to WCHS remains the same for this year. An average 397 new enrollees are identified each month. SSI recipients under age 5 are still referred for Child Service Coordination services, while those ages 5 and older are contacted by letter. The purpose of both contacts is to make families aware of the array of services for which their child may qualify. The Children's Special Health Services Program continues to cover some equipment not covered under Medicaid. Among the SSI Recipients identified since the SSI database was created in mid 2005, 63% have a primary diagnosis within the ICD-9 category for Mental Disorders. The five leading diagnoses reported among those children with a mental disorder are: Attention-Deficit/Hyperactive Disorder (23%), Speech-Language Delay (20%), Mental Retardation (19%), Autism (10%), and Oppositional Defiant Disorder (5%). These percentages do not include those children with a secondary diagnosis within the Mental Disorders

category.//2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	matching data files	10.7	7.4	9.1

Narrative:
/2008/Data from calendar year 2005 did not show any major changes in trends for this indicator, although it is concerning that the numbers of infants of low birth weight continue to increase slightly each year.//2008//

/2009/Data continue to remain almost constant for this indicator, with no major changes since 2001.//2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2005	matching data files	10.6	6.6	8.8

Narrative:
/2008/Data from calendar year 2004 show that infant deaths increased across all these populations, Medicaid, non-Medicaid, and the population as a whole.//2008//

/2009/Data from calendar year 2005 show that infant death rates did not change much from 2004 rates for all three population groups.//2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	74.3	92.9	81.9

Notes - 2009
Data for this indicator differ from NPM#18 because this indicator is based on CY2006 data and NPM#18 FY2006 is really CY2005 data. This indicator matches the data listed under FY2007 in NPM#18.

Narrative:
/2008/Data for calendar year 2005 show a slight decrease in the percent of infants born to women receiving prenatal care in the first trimester. This decrease is evident in all three population groups.//2008//

/2009/Data from calendar year 2005 show that rates of infants born to pregnant women receiving prenatal care in the first trimester did not change much from 2004 rates for all three population groups.//2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	82.7	88.7	85.6

Notes - 2009
Data for this indicator differe from HSCI#4 because this indicator includes women ages 18 through 50 and HSCI#4 only includes women ages 14 through 44. Also, this is CY06 data, so it would match up better with FY07 data for HSCI#4 which is actually CY06 data instead of FY06 data which is CY05.

Narrative:
/2008/Data for calendar year 2005 showed a slight decrease from 2004 data in all three population groups.//2008//

/2009/Data for calendar year 2006 continued to show a slight decrease from 2005 in all three population groups for this indicator. The percentage of Medicaid women with adequate prenatal care decreased from 83.8% in 2005 to 82.6% in 2006; for non-Medicaid women the rate decreased from 89.3% in 2005 to 88.7% in 2006; and the percentage of all women receiving adequate prenatal care decreased from 86.7% in 2005 to 85.6% in 2006.//2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)		

Notes - 2009
As of January 1, 2006, children age 0 to 5 in NC whose family income is <200% of poverty are eligible for Medicaid.

Narrative:
/2008/The Medicaid eligibility levels for infants have been updated to show the changes which went into effect in January 2006.//2008//

/2009/There have been no changes to the Medicaid and SCHIP eligibility criteria since January 2006.//2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 200 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 6 to 18) (Age range to) (Age range to)	2007	 200

Narrative:
/2008/The Medicaid and Health Choice eligibility levels for children have been updated to show the changes which occurred in January 2006.//2008//

/2009/There have been no changes to the Medicaid and SCHIP eligibility criteria since January 2006.//2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2009
The state SCHIP program, Health Choice, does not cover pregnant women.

Narrative:
/2008/ As of the first year of implementation (October 2005 -- September 2006) of the Family Planning Medicaid Waiver, 5,034 patients were served by local health department family planning clinics. However, the total patients served by all approved providers were 13,630 patients.//2008//

/2009/There have been no changes to the Medicaid and SCHIP eligibility criteria since January 2006.//2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes

Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:
/2008/ The work of the SSDI project has continued throughout FY07. The current SSDI project period focuses on the MCH Block Grant ongoing needs assessment, performance/outcome measures, and Health System Capacity Indicators. The role of the SSDI Project Coordinator is to help increase the Section's capacity to utilize and analyze data and to improve data linkages.

The major accomplishment of the SSDI project in FY07 was the completion of the work by the NC Healthy Start Foundation on the Latina Infant Mortality Awareness (LIMA) focus group project. This project was undertaken in order to improve the understanding of Latina health knowledge, attitudes, and practices in North Carolina, which was identified as a need both during the Title V Needs Assessment and during the work of the State Infant Mortality Collaborative. Seven focus groups were conducted in seven North Carolina counties characterized by large Latino populations. Criteria for participation in the groups included: self-identifying as Latina, ability to speak Spanish, and being a woman between the ages of 18 and 49. Sixty-two women participated in the focus groups, which were all conducted in Spanish by a native Spanish speaker. In addition to the focus groups, eight key informant interviews were conducted with community leaders, providers, and public health staff.

The information obtained from the women was invaluable and their comments about these topics very telling. Overall, it was concluded that Latinas in North Carolina face many challenges in obtaining health care for themselves, their children, and their families. The qualitative study reaffirmed that knowledge is not always sufficient to change behavior, and that issues associated with immigration and poverty, as much as "cultural difference," account for many of the problems faced by the Latinas in the study. The results of the study were reported at a meeting of public health workers, from both state agencies and community partnering agencies such as March of Dimes and Ipas, an international reproductive health organization, but more work needs to be done to disseminate this information to others. A further qualitative study is planned over the next twelve months to look at Latino families with children with special health care needs as this is another area identified through the Title V Needs Assessment about which there is little known. The WCHS will again contract with the Healthy Start Foundation to do these focus groups.

One area of the SSDI program where progress is stalled is in working towards a data linkage of birth certificates and newborn screening records. Work on a new electronic birth certificate reporting system is ongoing, but delayed, so the rollout to the counties in North Carolina has now been pushed back to the middle of 2008. The planned work of the SSDI Project Coordinator with staff from the State Center for Health Statistics (SCHS) to match birth records and newborn screening files from the Laboratory Information System has thus been moved back to 2010 instead of during 2009 when originally planned.//2008//

/2009/Much has been accomplished in the past year. The WCHS Data Utilization Meeting was held in November 2007. The SSDI Project Coordinator (PC) planned the event with input from representative staff members within each branch of the WCHS. About 25 people attended the 1-day meeting, the purpose of which was to inform WCHS staff about some of the data resources of the State Center for Health Statistics (SCHS) and to share examples of successful data use in each branch.

The SSDI PC presented a lecture on the MCH Block Grant and Needs Assessment Process

to students in the Masters of Public Health Program at East Carolina University. A successful Epidemiology and Evaluation Team Poster Day was held in May. Results of the qualitative data project on Latino families with children with special health care needs conducted by the NC Healthy Start Foundation through funding by SSDI were shared at a meeting. A qualitative assessment of data capacity of each branch was completed, but the quantitative tool has yet to be developed. The SSDI PC, along with the Women's Health Network Supervisor, is participating in the State Preconception Health Surveillance Indicators Working Group.

One area of the SSDI program where progress is stalled is in working towards a data linkage of birth certificates and newborn screening records. Work on a new electronic birth certificate reporting system is ongoing, but delayed, so the rollout to the counties in NC has now been pushed back another year to the middle of 2009 instead of the original 2007. The planned work of the SSDI PC with staff from the SCHS to match birth records and newborn screening files from the Laboratory Information System has thus been moved back to 2011 instead of during 2009 when originally planned.//2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Tobacco Survey (every other year)	3	Yes

Notes - 2009

Narrative:
/2008/YRBS was conducted in NC in the spring of 2007, but results will not be available for some time. The NC YTS will be conducted in 2007 as well. In addition to these data sources, in 2005 the NC State Center for Health Statistics began conducting the Child Health Assessment and Monitoring Program (CHAMP) survey. The CHAMP survey is a follow-up survey to the NC Behavioral Risk Factor Surveillance System (BRFSS). The purpose of the CHAMP survey is to measure the health characteristics of children ages 1 to 17 in North Carolina, and in 2005, survey questions were included that asked parents about current tobacco policy measures and initiatives in North Carolina. Results of this study were published in the January/February 2007 issue of the North Carolina Medical Journal (Volume 68, Number 1, pages 17-22). Most parents that responded to the survey questions (90.1%) support stronger policies for tobacco prevention and also support restrictions on tobacco in schools (85.6% of respondents) and recreational areas and fast food restaurants (83.9%). The CHAMP survey is a useful addition to the other surveillance systems in North Carolina.//2008//

/2009/The 2007 North Carolina Youth Tobacco Survey (NC YTS) provides a critical source of public health data for understanding the scope of the tobacco problem and measuring progress toward overall goals among youth. The 2007 NC YTS is a comprehensive statewide representative sample of more than 7,400 middle and high school students. Every other year a core set of CDC tobacco-related questions are asked. In addition, states add questions related to local program factors. In 2007, together with the Health and Wellness Trust Fund, the Tobacco Prevention and Control Branch added questions regarding media, community participation and secondhand smoking attitudes. The sampling scheme is now intended to generate significant numbers for regional data (mountains, piedmont and coast). Overall response rates for the high school survey in 2007 was 78.3% and the middle school response rate was 83.3%.

Rates of reported current cigarette smoking (past 30 days) among both middle and high school students dropped from 2005 to 2007. High school dropped from 20.3% in 2005 to 19.0% in 2007 and middle school from 5.8% in 2005 to 4.5% in 2007. Smoking rates for middle school students in NC are lower than the national average of 6.3%, measured in 2006, and the state's high school rates are on par with the national average of 19.7%.//2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Data collection and analysis for the majority of the National and State Performance measures are done collaboratively by staff within the WCHS and the State Center for Health Statistics. Specific information regarding most of these measures, including data sources and trends, can be found in the narrative portions for each measure and the detail sheet. The CSHCN Survey data, used in Performance Measures #2-#6, are made available through MCHB. As there is only one year of data for these measures, no statements regarding trends can be made. For the majority of the CSHCN measures, state rates were better than the national result. Due to a small sample size, a state rate is not available for Performance Measure #6 regarding youth with special health care needs and their transition to adulthood. Only for Performance Measure #4 regarding CSHCN whose families had adequate private/public insurance does NC fall just a bit below the national rate.

/2009/ Data from the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN) were pre-populated into the respective National Performance Measures. Due to changes in the survey questionnaire (substantial additions to questions, wording changes, ordering and placement of questions, and skip pattern changes), only data for National Performance Measures #2 (families are partners in decision making and satisfied with services that they receive) and #4 (adequate health insurance) are comparable to the outcomes found in the 2001 NS-CSHCN. //2009//

B. State Priorities

Based on further review of the NC Comprehensive Child Health Plan (our five-year needs assessment), the list of priority needs was slightly modified during FY2001. The following list is the revised list of priority needs which was used from FY01 to FY05.

1. Strengthening public health infrastructure at state and local level
2. Reducing disparities in health outcomes (racial/ethnic, geographical, socioeconomic, and for persons with disabilities)
3. Assuring access to high quality care for all segments of the MCH population
4. Increasing access to high quality health and related services in school settings by increasing the nurse-to-student ratio in NC public schools to an average of 1:750 or less
5. Assuring that the school health curriculum used in NC public schools comprehensively addresses a range of health and related issues relevant to school age children
6. Improving nutrition and fitness among children and adolescents
7. Improving pregnancy outcomes for all women
8. Reducing unintended pregnancies
9. Improving childhood immunization coverage through full implementation of a statewide computerized tracking system
10. Effective organization and delivery of family support (psycho-social, care coordination, home visiting) services for children and families

The changes to the list include dropping two previous priority needs -- 1)reducing occurrence and severity of injuries (particularly unintentional injuries) among children and adolescents and 2)enhancing monitoring, consultation and technical assistance to regulated child care centers to assure conditions that protect and promote health status of children -- and adding two new priority needs -- 1)Reducing disparities in health outcomes (racial/ethnic, geographical, socioeconomic, and for persons with disabilities) and 2)assuring that the school health curriculum used in NC public schools comprehensively addresses a range of health and related issues relevant to school age children. In addition, wording of some of the other priority needs has been amended to make them clearer.

During FY03, the SMT defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. The purpose of defining the set of indicators was to be able to help the WCHS better define its mission and promote a common vision among staff. In addition, as these indicators are shared with stakeholders and policymakers, they provide information about how the work of the WCHS contributes to the welfare of the state. The process of defining the indicators also helped the SMT gain clarity about where evidence-based interventions exist and identify areas offering opportunities for improvement. Also, the choice of indicators helps Section staff understand core job responsibilities and evaluate performance as the indicators can be used in individual work plans. Another important outcome of the selection of indicators is that they allow for a more data-driven environment throughout the WCHS.

The first step at establishing core WCH indicators occurred during a SMT retreat of just branch heads and section level managers. After further refinement by SMT as successive meetings, these initial measures were then shared with the expanded SMT, which includes unit supervisors and other staff, for further feedback. The final set of WCHS Core Indicators are as follows:
1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age
3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders
11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

At the same time that the Section was developing these indicators, the NC DHHS decided to implement performance based contracting using logic models as a component of performance based management. Thus, during FY04, the SMT members were responsible for leading work groups to create logic models for each of the eleven core indicators. Both regional and central office staff contributed to the models which are almost in the final draft stage. Logic models are by design a work in progress that can be revised as necessary to more clearly and correctly depict causal relationships and integrate program activities.

Thus, when it came time to determine the state MCH priority needs as part of the needs assessment process, the SMT quickly realized that while the results of the needs assessment information could help fine-tune the logic models, particularly the intermediate and end outcomes, these results only strengthened the argument that the WCHS Core Indicators reflected the priority needs of the Section. As each state is permitted to report only 7 to 10 priority needs, the NAT was tasked with consolidating the original 11 indicators into 10 priority needs. The NAT brought back several suggestions to the SMT who decided upon the following 10 priority needs to be used in the MCH Block Grant for the next five years:

1. Reduce infant mortality.
2. Improve the health of women of childbearing age.
3. Prevent child deaths.
4. Eliminate vaccine-preventable diseases.
5. Increase access to care for women, children, and families.
6. Increase the number of newborns screened for genetic and hearing disorders and prevent birth defects.
7. Improve the health of children with special needs.
8. Improve healthy behaviors in women and children and among families.

9. Promote healthy schools and students who are ready to learn.
10. Provide timely and comprehensive early intervention services for children with special developmental needs and their families.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100	100.0	100.0	100.0	100.0
Numerator		234	230	242	220
Denominator		234	230	242	220
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY06 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), CPT-II, PPA, IVA, GA-I, GA-II, 2-MBD, Tyrosinemia Type II, and Homocystinuria (HCY).

Notes - 2006
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY05 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), CPT-II, PPA, IVA, GA-I, GA-II, 2-MBD, Tyrosinemia Type II, and Homocystinuria (HCY).

NOTE - Corrected data from 208 total cases to 242 in Spring 2008 based on spreadsheet sent from NC Public Health Lab.

Notes - 2005
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY04 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, VLCAD, and other tests which account for 2 cases.

NOTE - Corrected data from 228 total cases to 230 in Spring 2008 based on spreadsheet sent from NC Public Health Lab.

a. Last Year's Accomplishments

/2009/In 2005 and 2006, the State Laboratory of Public Health saw a sharp increase in the false-positive rate for Congenital Adrenal Hyperplasia (CAH) screening as a result of a change in the Perkin-Elmer test kit that is used by the laboratory. In response, the laboratory changed CAH testing methodology from Manual Delfia to AutoDelfia. The laboratory staff, follow-up program staff, and consulting pediatric endocrinologists subsequently raised the CAH abnormal cutoff value to lower the false-positive rate. In 2007 a decrease in the false-positive rate was observed, though not back to what it had been prior to the kit change.

Laboratory staff wrote and submitted the budget proposal for adding Cystic Fibrosis to the newborn screening panel. They also developed an on-line training course for health care providers on completing the Newborn Screening form and revised the form to comply with new Clinical and Laboratory Standards Institute (CLSI) guidelines for newborn screening. Staff participated in the Southeastern Regional Genetics Group (SERGG) Region IV MS/MS data sharing project and a CDC four state research project entitled "Projecting Impact of Newborn Screening Panel."

The follow-up program has developed a follow-up protocol for Cystic Fibrosis (CF) modeled after that of other states and the American College of Medical Genetics follow-up recommendations, as well as in consultation with pediatric pulmonologists from the three major CF centers in NC and the NC Newborn Screening Advisory Committee.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Initial newborn screening test performed on all blood spot samples received.			X	
2. Follow-up of borderline results with a letter to physician.			X	
3. Follow-up of abnormal results with a phone call to physician.			X	
4. Testing of repeat blood spots received following a borderline or abnormal screen.			X	
5. Continued interaction of state lab and medical center staff as relates to questionable results.				X
6. Contracts providing statewide coverage for consultation related to metabolic conditions.				X
7. 7. Work towards development of data linkage of birth certificates and newborn screening records.				X
8. Purchase of special formula for individuals with certain metabolic disorders through Nutrition Services.		X		
9. Monitoring of phenylalanine, tyrosine, and phe/tyr ratios in blood spots received from individuals with PKU in routine medical management.			X	
10. Newborn screening advisory committee quarterly meetings.				X

b. Current Activities

/2009/The metabolic follow-up program continues to fine tune aspects of the follow-up protocol in preparation for the addition of Cystic Fibrosis to the newborn screen and the C&Y Branch role in follow-up of abnormal screen results. Job descriptions for two new

positions to provide CF follow-up and education are being created. The follow-up coordinator is also investigating, with the advisory committee and laboratory, the timeliness of follow-up for newborn screens with borderline results. Recommendations to increase efficiency for borderline follow-up and alert health care providers of this effort are being established.

Staff from the state laboratory are in the process of designing a new state laboratory building. At the same time, a new Laboratory Information Management System (LIMS) is being developed. Staff are also in the process of developing Tyrosinemia I testing and are participating in the SERGG Retion III Specimen Exchange Program. They continue preparations for the implementation of CF testing, which includes finding space for CF testing and conducting an evaluation of methodology of IRT and DNA mutation.//2009//

c. Plan for the Coming Year

/2009/The laboratory will finalize plans for CF testing and move toward its implementation in early 2009. It is anticipated that additional state appropriations will be needed before CF screening can be implemented. The metabolic follow-up program will assume follow-up responsibilities once testing is implemented by adding two more staff positions dedicated to CF follow-up and educational outreach. Follow-up protocols will be completed prior to the addition of CF to the screening panel.

Tyrosinemia I testing will also start next year.//2009//

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	75	75	75	75	75
Annual Indicator	65.3	65.3	65.3	65.3	58.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	75	75	75	75	75

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/During FY07, family members participated in both C&Y and EI Branch activities and interagency committees. Members reviewed WCHS policies and were represented on local, regional and state EI councils. The parent members educated others by serving on the Governor's Commission for CSHCN, an oral health work group, a behavioral health work group, and a Medicaid Review Board. Members also participated on the planning team for medical home workshops, as members of Community Advisory Councils for tertiary medical centers, as supports for parents of infants in NICUs, and as advocates for pertinent legislative issues. Two parents sat on the Early Detection and Hearing Screening Advisory Board, one as a board co-chair.

Family Council (FC) members made the following presentations: Family as Culture at the C&Y Branch meeting; Impact of Services at the Eliminating Health Disparities Conference; and Families and Transition for the Carolina Health and Transition HRSA grant project. FC members partnered with the Family Liaison Specialist (FLS) to collaborate with key C&Y Branch, DHHS, and community provider staff on topics such as emergency preparedness, Kindergarten Health Assessment, medical home outreach, DHHS website redesign, and transition to adulthood issues. Four members participated in the AMCHP conference.

FC members worked with the Exceptional Children's Assistance Center (ECAC) and WCHS staff to strengthen Family Voices NC and the CMS Family to Family Health Information Center (F2F HIC). A staff member of ECAC and two FC leaders administered NC Family Voices. C&Y contracted with F2F HIC to develop and disseminate six medical home workshops across the state. FC members were key leaders in local collaboration teams that planned each workshop. All family involvement is supported by stipends for meetings and activities.

Members of the Family Council represent diversity with respect to race, gender, culture, geographic area, family composition, and child health needs.

The FLS staffed the activities of the FC and worked to increase understanding of members' roles in improving system outcomes. She assisted families on individual child and family issues and advised staff on the development and promotion of family perspectives, family centered care, care coordination, transition planning, medical home, and community resources.

The toll-free Help Line for CYSHCN continued receiving input from family members and dispensing information to them. Call data was compiled and presented regularly to the Commission on CSHCN and the FC. Persons with disabilities and family members continued to be an integral part of the ongoing work of the NC Office of Disability and Health (NCODH), housed within the C&Y Branch. Adults with disabilities were in key NCODH staff positions and engaged as consultants, trainers, and advisors. The Office's initiatives to improve access to health promotion and disease prevention services positively influenced systems of care for CYSHCN.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Involvement of families of CSHCN in WCHS through FAC, the Family Liaison Specialist, and planning committees.				X

2. Toll-free Help Line will continue to provide information and support for families of CSHCN.		X		
3. Parent members will continue to work with the NC Commission on Children with Special Needs, the newborn hearing and metabolic programs, and receive standing invitations to Branch meetings.				X
4. At least two representatives from the Family Advisory Council will attend AMCHP conferences.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/In FY08, the FLS is working with families to address components of the SSU logic model.

The FC continues to develop its roles of advising, planning, and advocacy for increased family professional partnerships.

The Council continues to work with stakeholders to support EI outcome measures and review/comment on the federal Part C grant application. FC collaborates with the F2F HIC to present Medical Home Family education workshops across the state. Using the medical home questions from the National Survey of CSHCN, members are conducting phone surveys to determine behavior change resulting from medical home workshop content. The Council and other family members present at national, statewide and regional conferences on topics as varied as medical home, family support group development, family leadership, IDEA eligibility, teen and family advocacy and family professional partnership. There is continued focus on increasing diversity in family representation and participation. New FC members represent fathers, men, Spanish-speaking families, grandparents, and young adults with disabilities.

Adults with disabilities provide guidance to shape services for CYSHCN. The NCODH has launched many community-based demonstration efforts, implemented by teams of individuals with disabilities, to improve access to fitness environments, medical care clinics, cancer screening, and worksite health promotion. NCODH also reactivated its advisory council.//2009//

c. Plan for the Coming Year

/2009/In FY09, the Branch will continue work with families to address components of the SSU logic model. The FLS will assemble teams of internal and external advisors to increase family involvement and improve family professional partnerships across the Branch. Outputs for FY09 will include:

-Garnering input from the FC, community partners, and Branch leadership to create a strategic plan for family involvement within the C&Y Branch.

-Ongoing and accelerated work with C&Y Branch Units to increase family involvement across program areas as well as identification of ways for families to increase input to the Branch decision-making process. Family and Branch key initiatives will include Medical Home, Transition, School Health, and Workforce Development.

-Increased involvement of FC members and other family members of CYSHCN in planning, implementing, and evaluating Branch activities.

- Ongoing strategic planning to expand family participation at the local and regional levels. Members of the FC will create a brochure, investigate the feasibility of a newsletter, and

develop a community education curriculum about Title V. Efforts will focus on development, expansion, and review of strategies that assure that FC members function as liaisons with parents in local communities, the C&Y Branch, and other advocacy groups.
-Planning for the MCHB 5-Year Needs Assessment as it relates to CYSHCN programs and engaging parents as partners.

Additional areas of collaboration among families and professionals include the Kindergarten Health Assessment, CHAT curriculum and evaluation, CSC survey, Hispanic family CYSHCN survey, DHHS website redesign, Parent Family Leadership, Early Hearing Advisory Committee, Medically Fragile Child Care Clinical and Program advisories, and Family Professional Partnership Workshop.

The training partnership with MCHB funded leadership programs at UNC graduate schools of Public Health, Nutrition, Social Work and the Leadership Education in Neurodevelopmental Disabilities (LEND) program is ongoing. The FLS will develop a plan to incorporate a leadership model that utilizes Branch employees.//2009//

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	75	75	75	75	75
Annual Indicator	55.6	55.6	55.6	55.6	46.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	75	75	75	75	75

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

/2009/The NC Medical Home Initiative for CYSHCN continued to be a priority area of focus for planning, collaboration, and resource development during FY07. The NC Medical Home Initiative (MHI) was designed to integrate with the existing Title V and primary care infrastructure and to use processes and approaches with demonstrated efficacy in building systems of care for children and their families in this state.

The Medical Home Strategic Planning Group recruited external partners and began implementing logic model activities. The C&Y Branch management held a medical home retreat. The MHI Workgroup's membership also grew to include additional health care professionals and families.

Activities included:
-The Carolina Health and Transition (CHAT) project focused on research, training, advocacy, and awareness strategies with youth, families, and adult and child health care providers to support the successful transition of CYSHCN to adult health care within a medical home.
-Four practices within the Partnership for Health Management have incorporated the medical home index and family survey tools, pre-visit contacts, CYSHCN registries, and complexity ratings in their practices.
-Chapel Hill Pediatrics (CHP) received a commendation from Monique Fountain of MCHB in the "Promising Approaches" document of the Federal Expert Workgroup on Pediatric Subspecialty Capacity for its inclusion of the pre-visit contact. Data from Blue Cross/Blue Shield of NC again indicated emergency room utilization for CYSHCN was significantly lower in this practice than in other area practices.
-The HRSA supported Early Health Detection and Intervention Program and MHI continued their collaboration to monitor children with hearing loss. A survey of Community Care of North Carolina (CCNC) networks was conducted and 9 practices were chosen to receive hearing equipment, training, and consultation.
-The Exceptional Children's Assistance Center (ECAC) contractor completed 6 regional workshops for families on choosing a quality medical home.
-Students conducted interviews and surveys about the use of the Kindergarten Health Assessment (KHA) as a communication tool, among families, providers and schools. New materials supporting the KHA were created for statewide use. Child health KHA data was collected from ten counties in the state as part of a pilot.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate the families of children enrolled in HCheck and NCHC on the importance of the medical home.				X
2. Support systems of care that assure children are screened early and often for special health care needs.				X
3. Maintain toll free Help Line for referral of CSHNC to appropriate programs, services and providers.		X		
4. Conduct presentations on the Medical Home Initiative at statewide professional meetings.				X
5. Widely disseminate educational information and materials developed specifically for increasing medical home awareness with parents of CSHCN.			X	
6. Support systems of care that assure CSHCN are linked with a medical home for follow-up.				X
7.				
8.				

9.				
10.				

b. Current Activities

/2009/In FY08, representatives from the C&Y Branch and the MHI Workgroup held ongoing strategic planning sessions with key partners to clarify the role of local health departments, school health centers, the MHI Workgroup, and DPH in the MHI.

Other activities included:
-The CHAT project team piloted strategies to educate medical providers on becoming a quality medical home and empower youth and families to effectively partner with providers on transition to adult health care.
-Partnership for Health Management (P4HM) expanded its medical home activities into 3 new practices.
-CHP developed a plan to expand care coordination, began an initiative on healthy living and obesity prevention, and provided support to other pediatric practices in the state.
-C&Y Audiology Consultants and Branch staff trained 9 practices in the use of OAE/tympanometry equipment and logs to screen and monitor children under age three. Each practice completed a provider medical home index, surveyed 3 families about quality of care, and is developing practice registries and tracking and follow-up protocols.
-ECAC held train-the-trainer medical home workshops for health and disability advocacy groups that work directly with families.
-Outreach activities were conducted to improve completion of the KHA and to enhance communication among medical home providers, school staff, and families.
- Negotiations are ongoing with CCNC to partner in community grants to enhance systems of care for CSHCN.//2009//

c. Plan for the Coming Year

/2009/During FY09, the NC medical home strategic plan will be developed. The roles of public health and its partners will be clearly defined and will guide the future work of the MHI.

Other activities will be as follows:
-The CHAT project team will pilot its training and advocacy materials through statewide training sessions and will build on its collection of data for evaluation of the project. The team has created an interactive collaborative among youth, family and medical providers around transition in NC, and work continues with this collaborative. The CHAT project team will hold a statewide conference to develop a State Plan on Transition. CHAT project staff will seek additional sources of funding to sustain its activities beyond the grant funding period.
-P4HM will expand medical home concepts into at least two additional CCNC networks in North Carolina and provide training and technical assistance to practices adopting the medical home model.
- A social marketing campaign will be implemented to improve use of the KHA as a communication tool with medical home providers, schools, and families. This campaign will also promote the use of a medical home for ongoing well child care.
-The "How to Make Your Doctor's Visit Work For You" bookmark will be updated. This is a companion piece to the Medical Home bookmark.
- The C&Y Branch will continue to partner with a wide range of key stakeholders to promote the medical home concept.
The Branch will continue to support the efforts of the Improving Pediatric Access through Collaborative Care (IMPACC) program which focuses on co-management by the specialist and the primary care provider for individuals with chronic health conditions.
-Medical Home Initiative partners will collaborate with the NC Pediatric Society on efforts

to increase awareness of need for and use of a medical home for all foster care children. - The National Survey of CSHCN data related to medical home components and its positive relation to addressing transition needs for youths will be used for service planning improvements.//2009//

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	80	80	80	80	80
Annual Indicator	57.3	57.3	57.3	57.3	63.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	80	80	80	80	80

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/Behavioral health issues continue to be the leading health conditions reported to the CSHCN Helpline by families. Most communities in the state do not have the capacity to meet the behavioral health service needs of children. The Behavioral Health Workgroup of the Commission on CSHCN continued to monitor the steadily rising costs and utilization of behavioral health services among children covered by NC Health Choice (NCHC). Of notable concern was the very high increase in use of community support services. Because of changes in the mental health service definitions at the federal level, the enhanced behavioral health service package for NCHC was expanded to include targeted case management for children with a sole developmental disability diagnosis.

Other activities included the following:
-With the legislative requirement of NCHC case management services through Community Care of North Carolina (CCNC) networks beginning in March 2007, the Commission on CSHCN provided claims data to help CCNC staff link children who were not currently in a CCNC network and assess outstanding case management needs of these children.

-Statewide education seminars for providers were conducted in Spring 2007 to provide updated information on behavioral health services definitions, policies, and procedures.

-The CSHCN Helpline received over 1,500 calls during which access to health insurance and related services for over 1,100 children under age 21 were discussed. Among the total children discussed, 70% had special health care needs. The percentage of calls from or related to Spanish-speaking families/children rose to 12% as compared to 7% the previous fiscal year. The Helpline has direct access to bi-lingual specialists through the NC Family Health Resource Line. Helpline staff was able to educate callers on multiple public programs and system access issues.

-The C&Y Branch continued to strengthen the capacity of the NC Family Health Resource Line to help families understand the importance of maintaining health care coverage and their rights when transitioning CYSHCN from one insurance plan to another.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain HC/NCHC Outreach Campaign in coordination with the NC Healthy Start Foundation, DMA, State Employees Health Plan and DMH//DD/SAS.			X	
2. Maintain NC Family Health Resource Line as a bilingual informational telephone hotline.			X	
3. Continue to expand HC/NCHC Outreach web site.				
4. Continue to expand HC/NCHC educational campaign regarding medical home/ER use/preventive care.			X	
5. Simplify enrollment/re-enrollment forms and develop/disseminate family-friendly notices.		X		
6. Develop comparable data sets for HC and NCHC.				X
7. Target outreach to special populations (including minority and CSHCN).			X	
8.				
9.				
10.				

b. Current Activities

/2009/Activities for FY08 include:

-The Commission on CSHCN is developing key priorities and a strategic 3 year plan.

-The Commission's Behavioral Health Work Group continues to monitor cost of services to NCHC children, identify areas of significant change in use, and make recommendations to Medicaid and the Secretary of DHHS.

- Educational sessions for community support providers were provided. Agency-specific data will be tracked to monitor trends in service frequency.

-The Family Council for CYSHCN continues to promote the importance of obtaining and maintaining health insurance and having a quality medical home through statewide educational sessions.

-The English version of the NCHC special needs booklet was revised to incorporate program changes related to behavioral health services. A Spanish version of the booklet was developed. Both booklets are on the NCHC website.

-Programming changes to the CSHCN Helpline database are being completed to improve the quality of data collected from callers related to insurance and other associated topics.

-Two articles on Helpline data will be developed and distributed. The first article will

outline the development and function of the database and the second will discuss behavioral health concerns among CYSHCN reported by callers.
-A proposal for expanded coverage under EPSDT and legislation for insurance coverage for children up to 300% of Federal Poverty Level has been proposed for consideration by the General Assembly.//2009//

c. Plan for the Coming Year
/2009/The Commission on CSHCN will finalize its strategic plan and focus on key priorities.

A Case Management Work Group will collaborate with CCNC to assist in provision of case management services for NCHC CSHCN. The Branch will continue to work with the State Employee's Health Plan (SEHP) to obtain updated claims data for CCNC on a regular basis to identify additional CSHCN in need of case management services.

Effective July 1, 2008, the SEHP's insurance coverage called the indemnity model will be replaced with a preferred provider organization model. Health Choice is benchmarked to the SEHP indemnity model by state law. The C&Y Branch is working with the Division of Medical Assistance (DMA) and the SEHP to prevent a disruption in access, quality, or claims processing as a result of the transition of children under NC Health Choice from the indemnity to the preferred provider model. DMA, DPH, the State Employees' Health Plan, and the Commission on CSHCN meet monthly to assure a high level of coordination in program services for Health Choice children.

The Commission's Behavioral Health Work Group will continue to monitor the rising costs and utilization of community support services for NCHC and Medicaid children and make recommendations to DMA and the Secretary of DHHS. Educational sessions for identified NCHC providers will continue to be offered as needed.

The Commission will continue to monitor state and federal legislation that impacts CSHCN. The Commission will make recommendations and advocate for specific legislation and policies as appropriate.

The C&Y Branch continues to lead a statewide group of key partners in planning and implementing the medical home concept in NC. Barring budget reductions, funds will be provided to communities in the upcoming fiscal year that will target improved systems of care for CSHCN. Planning is underway with Community Care of NC to jointly support these efforts which will include services for the uninsured.//2009//

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	90	90	90
Annual Indicator	80.6	80.6	80.6	80.6	89.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/In order to increase awareness of resources at state and community levels, C&Y program managers and regional staff in physical therapy, speech and language, audiology, genetics, child health, child care, and school health have provided technical assistance and training to families, therapists and provider agencies.

The C&Y Branch partnered with private and public agencies to support cultural diversity training and other means of assuring that families receive family-centered, accessible, inclusive, and culturally and linguistically competent services. Discussions with the National Center for Cultural Competency persist in order to continually improve the quality of services to families.

The C&Y Branch provided clinics and services for CYSHCN through local and non-local contracts. The Community Transition Coordinator program screened records at major birthing hospitals and linked families to services within the community. The CSHS, Cystic Fibrosis and AT funds were used to reimburse for services not covered by Medicaid, NC Health Choice, or private insurance.

A statewide network of seven Assistive Technology Resource Centers (ATRCs) loaned an extensive number and variety of devices to families and service providers. They provided consultation, technical assistance, demonstration, and training on assistive technology devices, services, strategies and funding. A new brochure was developed and will be used to increase awareness of this service.

Child Service Coordination program (CSCP) services were available in each county through local health departments to offer care coordination for families of children at risk for or diagnosed with developmental delays, chronic illness, or social/emotional disorders. The program served 34,989 children during the year.

The CSCP developed an outreach campaign to link more families with services, improve data reporting accuracy, and enhance program evaluation. Committees of local providers were organized to obtain input on policy revision and documentation issues. The program developed and distributed data reports to assist providers in program planning and evaluations. The CSCP developed and implemented several strategies to ensure that quality services were available to all eligible families, which included continuing education

for providers and supervisors (over 450 participants); orientation training for new staff (135 participants); development and implementation of a process by which provider's policy questions were jointly answered by DPH and DMA; and the distribution of electronic program updates. The program shifted to a new technical assistance model when child health nurse consultants became the primary CSCP contact for technical assistance and monitoring. The CSCP Manager began a project that focused on linking children in domestic violence shelters with community services. The Program Manager continued to collaborate with DMA on issues including policy revisions, revision of provider forms, and eligibility criteria. Work continued on the Early Comprehensive Children's Services grant including updating the Shared Indicators for School Readiness. Partners applied the indicators in agency planning, accountability and service delivery in order to effect system improvement to impact child well-being and school readiness.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Community Transition Program.			X	
2. Continue Child Service Coordination Program.		X		
3. Continue provision of Early Intervention services and implementation of system design changes.	X			
4. Continue CSHS Clinics.	X			
5. Continue Special Needs Helpline.		X		
6. Continue child care for children who are medically fragile.	X			
7. Continue to advocate for additional school nurses and provide education and training to enhance their intervention skills in work with CSHCN.				X
8. Develop infrastructure to support transition services.				X
9.				
10.				

b. Current Activities

/2009/FY08 activities include:

-A multi-agency effort to improve linkages for families of domestic violence to community services continues.

-The CSC Manager, DMA staff, and family representatives developed a Family Satisfaction Survey for care coordination recipients.

-Community transition services assist families with hospitalized children (age 0 to 5) to connect with appropriate community support services.

-ATRCs are implementing a customer satisfaction survey.

-The contract for the medically fragile child care center is being continued while DMA pursues an amendment to the CAP C waiver to provide Medicaid coverage for qualified children.

-The FLS works with C&Y programs to increase family inclusion in planning, education, and other activities.

-Key stakeholders, including families, continue work on a state plan for development of medical homes.

-An Alliance for Evidence-Based Family Strengthening Programs work group was convened to establish multi-agency support for evidence-based parenting programs. Members include DPH, DSS, DMH/DD/SAS, the NC Partnership for Children, The Children's Trust Fund, The Duke Endowment, Kate B. Reynolds Charitable Trust, researchers, and practitioners. These agencies will support up to eight Nurse Family Partnership projects through combined funding. Evidence-based parenting programs will be funded in FY09 by the C&Y Branch.

-Partnership grants at the community level are being developed to enhance systems of care for CSHCN.//2009//

c. Plan for the Coming Year

/2009/Activities that will done by C&Y Branch staff members in FY09 to improve community-based service systems include:

- Data reports for the CSCP will continue to be used for program planning and evaluation at the state and local level. The Family Satisfaction Survey will be implemented and results will be collected and analyzed periodically. Workforce development strategies to ensure all eligible families receive quality services will continue.

-In order to gain a better understanding of the extent to which community based services are accessible and are adequately addressing the needs of families of CYSHCN, the FLS will increase family involvement across the C&Y Branch and obtain information on family satisfaction through surveys, focus groups and direct involvement.

-Transition services for young children will involve the CSCP, EI Branch, and public school system. Community transition coordination will continue to assist families moving from tertiary care hospitals to communities. Funding for the medically fragile child care center will be depleted at the end of August until (or if) a Medicaid waiver is successfully implemented.

-The ATRC database will be improved and expanded, with additional training on data entry for better program planning. Outreach activities to families and service providers will be enhanced; including conduction of community needs assessments and Spanish translation of the ATRC brochure.

-Creation of a web site to increase access to program information, equipment loan services and resources will be pursued.

-PT consultants will expand local trainings to increase skills, number, and distribution of local therapists serving CYSHCN.

-The C&Y Branch plans to offer funding for a number of pilot efforts to improve systems of care for CSHCN. This is being jointly planned with the Community Care Network of NC and will address comprehensive issues connected with quality medical homes and support systems of care.

-The C&Y Branch is completing an assessment and plan to increase the support for CSHCN in child care settings.

-Ongoing efforts are occurring to improve the use of Kindergarten Health Assessment information to enhance communication among families, schools and providers about CSHCN and their medical needs in the school setting.

-The collaboration between private providers and school nurses is being formalized in order to provide seamless and consistent care for CSHCN.

-A plan is being introduced to encourage health departments to hire behavioral health specialists and outstation them in private practices. In the upcoming year, grantors will be supporting 59 co-location projects between behavioral health and private practices, but this is the final year of grant funding. C&Y Branch staff are trying to develop a sustainability and expansion plan for this work.

-The toll free CSHCN Helpline provides ongoing support to link families to community and specialty services and funding sources.//2009//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective			5.8	5.8	5.8
Annual Indicator	5.8	5.8	5.8	5.8	39.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	45	45	45	50	50

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2009/A primary effort of FY07 was the implementation of the Carolina Health and Transition (CHAT) project. Three initial Transition Work Group (TWG) meetings served to educate participants about the project and about medical home and transition issues faced by YSHCN. Opportunities were presented for Work Group participants to review and comment on transition materials developed for families. These meetings enabled all members to gain a deeper understanding of health care transition and medical home from the perspective of each stakeholder group (youth, provider and families). These meetings also provided a forum to develop common terminology in discussions, related activities and initiatives across the state and to define additional resources that could benefit this effort. A project coordinator was hired. Contracts were developed with youth, family, and medical provider agencies in the community to develop a curriculum and create an interactive collaborative among these groups. Contracts for these three initiatives were executed in February 2007 and continued into FY08. Currently, the Alliance of Disability Advocates, Center for Independent Living (CIL), holds the contract for the youth initiative, the Exceptional Children's Assistance Center (ECAC) holds the contract for the family initiative, and the Mountain Area Health Education Center (MAHEC) holds the contract for the medical provider curriculum. In addition to attendance at quarterly TWG meetings, key staff members of the three agencies have attended quarterly meetings of the NC Office on Disability and Health (NCODH) Advisory Council, met via conference calls, reviewed available medical home and health transition materials from national resource groups such as Healthy and Ready to Work, and participated in email discussions to clarify operational definitions for the project.

The CHAT project, in coordination with the C&Y Branch, added one question to the NC

Children's Health Assessment and Monitoring Program (CHAMP) survey to better identify the family-centered component of medical home. Due to the small sample size of the CHAMP survey, it was decided to promote the inclusion of three additional health transition related questions for the 2008 NC BRFSS.

An informational packet of health care transition materials was developed by the project in collaboration with NCODH and disseminated at high school transition fairs for students receiving special education services. In collaboration with NCODH, the Specialized Services and the School Health Units of the C&Y Branch presented a workshop on healthy transitions to public school staff at the NC Coordinated School Health Programs Conference in July 2006. A packet of transition and medical home related materials for families of YSHCN was reviewed by the TWG to be disseminated through the CHAT's family initiative.

Youth are strongly represented on the TWG and within the Youth Initiative. In January 2007, the CHAT project co-sponsored the NC Youth Leadership Network's (NCYLN) NC Youth Summit and the NC Easter Seals-United Cerebral Palsy Youth Leaders in Action's college conference, New Horizon, Taking the Next Step: Preparing Youth with Disabilities for Secondary Education. Both conferences were planned by youth leaders for youth. Project staff members presented a workshop on healthy transitions for the summit and a panel presentation on health and wellness opportunities on college campuses for the Youth Leaders in Action conference.

CHAT staff also worked with the medical provider initiative to coordinate a three-day working conference with the Healthy and Ready to Work National Resource Team. This meeting took place in April 2007 and provided on-site technical assistance to the CHAT Project with a focus on preparing systems, services, families and youth for health care transition from pediatric to adult systems of care. It also provided an opportunity for the medical, youth and families initiatives to come together and coordinate their individual efforts.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide a greater focal point for transition, by diffusing transition responsibilities across the C&Y Branch and by inserting transition linkage responsibilities into job descriptions				X
2. Through the HRSA grant's CHAT project, provide training, identify needed policy changes, identify and develop community resources, and provide information.				X
3. Continue training and TA to YSHCN, families and providers .				X
4. Provide TA on youth leadership development and access to health care to the NC Developmental Disabilities Council.				X
5. Collaborate with the School Health Program and other WCHS planning bodies, to include youth with disabilities in an advisory capacity for Title V programs.				X
6. Promote transition as a focus in planning for medical homes for CSHCN.				X
7. Continue to use the National Survey of Children with Special Health Care Needs data in planning transition efforts and galvanizing support.				X
8. Continue participation in the DHHS Eliminating Health Disparities Initiative.				X

9. Collaborate with provider associations, and other Departments to support transition.				X
10.				

b. Current Activities

/2009/CHAT contracts continue with the initial contractors to develop the youth, family, and medical provider curriculums. In addition to these contractors, contracts were entered into with two other agencies to support expanded work of the project: East Carolina University - to incorporate the use of care coordinators in medical offices transition efforts, and UNC-Chapel Hill Center for Development and Learning - to incorporate the use of video scenarios and advocacy techniques in the work with youth. Feedback from focus groups held throughout the summer and fall of 2007 assisted the three specialty groups to complete their respective curricula.

The curricula are currently being reviewed by HRTW and the DPH CHAT project team for final changes, and the public affairs design staff are preparing the artwork and presentation format for the project. The DPH graphics designer is working with each manual to provide a consistent format and logo for the project. These efforts will be complemented by a set of marketing materials.

In addition to the hardcopy materials, the youth initiative has incorporated the use of video scenarios to provide additional avenues for delivering the transition message to youth who have different cognitive or other disabilities.

Presently, preparations for the annual project meeting continue with members of the HRTW team who have been instrumental in supporting CHAT project activities and providing feedback and recommendations.//2009//

c. Plan for the Coming Year

/2009/ CHAT project efforts will switch to a focus on implementation and sustainability. Each of these phases will be carried out according to the structure outlined in the original HRSA grant. However, given the success with promoting transition throughout the state, additional activities are planned that will enhance current efforts. In addition to using the CHAT curricula to provide training focused on youth, family, and medical provider audiences, the C&Y Branch is also planning to conduct training for teams made up of individual youth, family members, and the youth's provider. Our goal with the team training is to ensure that the information provided is relevant to each member of the transition team, as well as to obtain feedback on how well each is prepared for the transition process. A project evaluation is being conducted during the implementation phase which will monitor success.

Sustainability efforts will require multiple layers of activities. Since the HRSA grant is scheduled to end in FY09, the project management team has been exploring additional sources of funding to continue the work of transition within the state of NC. The team is collaborating with various partners in the State who are interested in promoting and increasing transition activities for YSHCN. A statewide transition conference is being planned for Fall 2008. A primary goal of the conference is to convene key partners to review transition-related activities within the state, identify ongoing needs/resources, and develop a strategic plan to sustain and broaden transition activities.

The 2005-06 National Survey for Children with Special Health Care Needs data related to medical home and transition have been analyzed. Results indicate that nearly 60% of YSHCN in NC are still not receiving transition related health care services. In addition to the national survey, transition related data from other statewide sources such as the

BRFSS and CHAMP continues to be reviewed. Recent meetings with UNC-Chapel Hill, Community Care of NC, DMA, and Health Choice have provided additional opportunities to obtain data on YSHCN who are ready for transition.

Future plans include collaborating with school systems to broaden the factors included in transition plans for students with Individual Education Plans. Members of the Department of Public Instruction are on the transition advisory team and welcome the idea of including CHAT curriculum components into their transition planning. The idea of health care transition has been introduced to the State School Health Nurse Consultant who has agreed to include and support outreach, training, and technical assistance for school health nurses.//2009//

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	85.6	86.2	85.2	82.2	82.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90

Notes - 2007
Data are from the National Immunization Survey for the Q3 2006 to Q2 2007time period (July 2006 to June 2007). As this is a weighted estimate, data for the numerator and denominator are omitted.

Notes - 2006
Data are from the National Immunization Survey for the Q3 2005 to Q2 2006 time period (July 2005 to June 2006). As this is a weighted estimate, data for the numerator and denominator are omitted.

Notes - 2005
CY2005 data are from the National Immunization Survey. As this is a weighted estimate, data for the numerator and denominator are omitted.

a. Last Year's Accomplishments
/2009/The latest published National Immunization Survey (NIS) results showed that for the Q3 2006 to Q2 2007 time period (July 2006 to June 2007) , NC coverage remained high as 82.4% of children in the target age group were fully immunized (4:3:1:3:3). The staff of the Immunization Branch (IB) continues to work to raise this rate. In October 2005, statewide deployment of the NCIR to all 100 local health departments (LHDs) was completed. Full system development was also completed. By the end of FY07, the system had been fully deployed to over 50% of North Carolina's Universal Childhood Vaccine Distribution

Program (UCVDP) providers. In addition, to raise immunization rates among 19-35 month year olds, the Branch developed a DTaP 4 initiative which, in collaboration with Nutrition Services Branch, was kicked off by the IB in August 2006. Statistical analysis of North Carolina immunization data suggested that the up-to-date rate for DTaP was significantly lower than for other vaccines in the 4:3:1:3:3 series. Educational materials were distributed to providers which indicated that the "drop off" of immunization rates is most likely to occur with the fourth dose of DTaP, and the need to administer the fourth dose of DTaP on time was emphasized. According to the FY07 NIS, the completion rate for the four dose series of DTaP still lags behind those of other vaccines; however, FY08 NIS data should provide a better measure to determine the effectiveness of the DTaP 4 initiative.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintenance of the Universal Childhood Vaccine Distribution Program.			X	
2. LHD assessment and tracking activities.				X
3. Complete at least 234 AFIX visits in calendar year 2008.		X		
4. Update the Immunization Branch web site as necessary.			X	
5. Continue deployment of the statewide registry to the remaining private providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/In FY08, IB staff encouraged LHDs to raise immunization rates by using the assessment and reminder/recall tools of the NCIR. NCIR system enhancements were implemented, making the tools more accurate and user friendly. NC was recognized at the 2008 National Immunization Conference for having the second highest coverage rate for the 4:3:1:3:3:1 series in CY06. The DTaP 4 initiative continues. IB staff members continue recruitment and registry readiness efforts with private providers statewide. The goal for NCIR statewide deployment is to enroll 75% of private providers by the end of FY08. Currently, including the LHDs, the total percentage of UCVDP providers using NCIR is 50%. The IB chose to slow deployment efforts in FY08 in order to undertake inventory and data cleanup efforts among current NCIR users. Data analysis and reports from field staff indicated that the inventories of many NCIR providers did not reflect accurate accountability or doses administered data. Despite the probability that the FY08 deployment goal will not be met, the accuracy of NCIR data has improved. The proposed collaborative effort between the IB and the State Health Plan to conduct a pilot study of the Universal Vaccines for Children Initiative was abandoned. Instead, the IB collaborated with the Rural Health Centers to deputize all of the providers participating in UCVDP, enabling all underinsured children seen by any UCVDP provider to receive state-supplied vaccine.//2009//

c. Plan for the Coming Year

/2009/During FY09, the Immunization Branch will continue statewide deployment efforts for the NCIR. The statewide deployment goal is to have 75% of providers on the NCIR by the end of FY09. Data cleanup efforts slowed deployment but increased the integrity of the data in the NCIR. Increased provider participation in the NCIR will help to ensure that

client immunization histories documented in the NCIR are complete. Immunization Branch staff will continue to train providers on the utilization of NCIR reminder/recall tool. Greater use of these tools by providers should help to increase the overall completion rate of the 4:3:1:3:3 series in North Carolina. In addition, inventory management training will be provided to all new NCIR providers at the time of deployment. To increase deployment efforts, the Immunization Branch is considering hiring temporary staff to focus strictly on NCIR deployment. The initial focus for these individuals will be deployment to private providers in Mecklenburg, Guilford, and Wake counties.//2009//

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	32	30	26.5	26	26
Annual Indicator	28.6	26.9	26.8	26.7	24.6
Numerator	4589	4377	4425	4519	4306
Denominator	160414	163003	165361	169277	175313
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	24	24	24	24	24

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

Notes - 2006
FY year data are actually the prior calendar year, e.g. FY06 is really CY05.

Notes - 2005
FY year data are actually the prior calendar year, e.g. FY05 is really CY04.

a. Last Year's Accomplishments
/2009/Over the most recent three years for which data are available, North Carolina's adolescent pregnancy rate for 15-19 year-olds has plateaued after a 13-year decline that resulted in the state's lowest-ever rate of 61 per 1,000 in 2003. In 2004, 2005 and 2006 the adolescent pregnancy rates were 62.4, 61.7 and 63.1 respectively. Overall, the state's adolescent pregnancy rates in North Carolina have declined by nearly 40 percent since 1990.

During FY07, 62 teen pregnancy prevention projects were funded by the NCDHHS through the Teen Pregnancy Prevention Initiatives (TPPI). These projects included 31 primary prevention projects, or Adolescent Pregnancy Prevention Programs (APPP), and 31 secondary prevention, or Adolescent Parenting Programs (APP). TPPI has continued to be committed to reducing teen pregnancy in the counties with the highest teen pregnancy rates. In FY07, TPPI funded projects in four of the five counties with the highest teen pregnancy rates, and provided additional technical assistance to support these and other projects serving teens with high rates of teen pregnancy. In addition, the Adolescent

Pregnancy Prevention Coalition of North Carolina (APPCNC), through a contract with DPH, has continued to assist many of the highest need counties in developing local pregnancy prevention coalitions that facilitate local collaboration and support for a community-based organization to apply for TPPI funding.

APP targets first-time pregnant and parenting teens. A primary goal of the APP is to prevent second or higher order pregnancies. The program requires staff to provide comprehensive, medically accurate family planning information to all participants, including information on birth control and abstinence. Delaying a second pregnancy until after high school graduation and increasing the high school graduation rate among participants are primary goals of the APP, and the projects have been very successful at achieving these goals. Among 459 Adolescent Parenting Program participants in FY07, there were 9 repeat pregnancies. This is a repeat pregnancy rate of 2% compared to the state rate of 24.8% repeat teen pregnancies in 2006. Only 4.8% of participants dropped out of school compared to the overall school dropout rate of 5.24% among all public school students in North Carolina during the school year 2006-07.

APPP continued to build the capacity of local projects to implement best practice approaches to preventing teen pregnancy. Curricula such as Teen Outreach Program (TOP), Reducing the Risk, and Making Proud Choices, which are some of the most highly successful science-based curricula for preventing teen pregnancies, continue to be implemented. Other promising approaches, including Plain Talk and Wise Guys, were also implemented. Three projects served males exclusively, and nearly all other primary prevention projects included as many males as females in their programming. Three projects focused primarily on Latinos including one that targeted Latino families with an innovative curriculum called Plain Talk/Hablando Claro.

All currently funded TPPI projects are required to participate in an ongoing evaluation which includes both process and outcome data. The process evaluation data are reported via a web-based system that is a requirement of the grant and monitored by TPPI staff. The evaluation of outcomes involves the assessment of program impact on participants' abstinence/delay in initiation of sexual activity, participants' contraceptive use if sexually active, reduction in other risk-taking behaviors, and ultimately a reduction in the rate of adolescent pregnancy in the target group compared to a comparison group.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing support provided for Teen Pregnancy Prevention Initiative projects.		X		
2. Primary prevention projects participate in annual evaluation process.				X
3. All TPPI projects participate in a web-based process evaluation program.				X
4. Annual Teen Pregnancy Prevention Symposium (with the Adolescent Pregnancy Prevention Coalition of NC).				X
5. Annual Adolescent Parenting Graduation Conference.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/During FY08, 60 teen pregnancy prevention projects are receiving TPPI funds. These projects included 30 primary prevention projects and 30 secondary prevention projects. TPPI has continued to be committed to reducing teen pregnancy in the counties with the highest teen pregnancy rates and to eliminating health disparities. TPPI co-sponsored a conference with other programs within the WH Branch to increase collaboration among providers within communities in an effort to decrease health disparities.

TPPI is conducting an outcome evaluation of the APP in FY08. The evaluation will be conducted by a researcher at the School of Human Environmental Sciences at the University of North Carolina at Greensboro. The evaluation will examine the success of participants in achieving the goals of the APP.

APPP continues to build the capacity of local projects to implement best practice approaches to preventing teen pregnancy. All projects currently receiving funds are implementing a program from a list of evidence-based or promising programs.

In addition, TPPI and the APPCNC will co-sponsor an annual pregnancy prevention conference to provide participants with knowledge and skills to maintain best practices in teen pregnancy prevention programming.//2009//

c. Plan for the Coming Year

/2009/The RFA proposal process in the fall of 2008 resulted in eight proposals from projects that will receive funding for FY09. This will be a reduction of five programs, from a total of 60 in FY08 to 55 in FY09, due to a loss in Medicaid funds.

In FY09, TPPI will conduct the second phase of an outcome evaluation of the APP in which the evaluator intends to examine more qualitative data from focus groups with program participants. This evaluation will reveal the strengths of the APP model and the areas that should be improved to strengthen the model in the future.

The outcome evaluation plan for the APPP will continue to be improved in an effort to establish the efficacy of these primary prevention programs. The evaluation survey, which was updated in FY08, will undergo revisions, and local program coordinators will receive consultation on best practices for administering the surveys to the participants and comparison group members.

TPPI will continue to increase the implementation of best practice approaches to teen pregnancy prevention by local contractors receiving funding for primary prevention programs. A list of best practice approaches will be provided in the RFA and applicants will be encouraged to propose at least one for implementation. Consultation will be provided to applicants by TPPI staff at all stages of proposal development, and proposals will be selected based on the use of best practice or promising approaches.

During FY09, TPPI will support the efforts of local contractors to increase or improve the provision of family planning education to all adolescent participants and referrals of sexually active adolescents to family planning services. Training on family planning issues will be provided to local project staff at regional meetings. Additionally, all new proposals will be required to include a plan to provide family planning education and referrals, and applicants will be asked to describe their intentions to provide these services.

TPPI will also focus on addressing ethnic and racial disparities among Hispanic/Latino

youth. The FY09 RFA selection process will give special consideration to proposals that will serve this population. TPPI staff will work to establish collaborative relationships with other state and local government agencies, private organizations, and local Hispanic-focused efforts. Efforts to identify specific program objectives that address reductions in racial disparities in health indicators at the local level will continue.//2009//

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	50	50	50	50	50
Annual Indicator	37	41.0	43.0	44.0	42.0
Numerator		31452	33793	35453	36285
Denominator		76711	78588	80574	86393
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	50	50	50	50

Notes - 2007
These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Notes - 2006
These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

a. Last Year's Accomplishments
/2009/During the 2006-07 school year, data was collected on 86,393 of fifth grade schoolchildren (81%). The proportion who had dental sealants was 42 percent. As part of state supported sealant promotion projects and using a small supplement from Preventive Health and Health Services Block Grant funding, the Oral Health Section (OHS) provided 14,767 sealants for 3,489 children during 57 sealant projects.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Statewide dental assessment of oral health status conducted in alternate school years (even years).				X
2. Staff driven and community-based sealant projects conducted.	X			
3. Educational services provided in various settings.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/This year, the OHS will once again focus on providing dental sealants for schoolchildren at high-risk for dental decay. Over the years, funding from the Preventive Health and Health Services Block Grant has decreased by 70% and a number of staff retirements are planned. OHS hopes to provide approximately 13,000 sealants.//2009//

c. Plan for the Coming Year

/2009/Assuring that children at high risk for tooth decay get dental sealants continues to be one of the OHS's top priorities. Preventive Health and Health Services Block Grant have decreased dramatically. Getting parental permission for their children to get sealants is increasingly difficult. This problem does not seem particular to sealants, but just that communication between schools and parents is getting more and more difficult - that permission slips are sent home, but never seen by parents or returned to school by the children. There could also be growing concern regarding patient information and the desire for privacy. Even with these barriers, however, OHS hopes to continue to provide sealants to those children at highest risk.//2009//

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	5	5	4	4	4.5
Annual Indicator	5.3	4.5	5.5	4.7	5.0
Numerator	90	78	96	82	90
Denominator	1706584	1717971	1731988	1751959	1788230
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.5	4.5	4	4	4

Notes - 2007

Data are for the calendar year preceding the fiscal year (2007 data are for CY2006).

Notes - 2005
In June 2001 all annual indicators for this measure (1991 - 2000) were revised to reflect the new age group (<14 years versus age 1 to 14) as indicated on the detail sheet with the guidance for the FY02 Block Grant. Data are for the calendar year preceding the fiscal year. In August of each year, the NC Office of State Planning releases certified population estimates for North Carolina and its counties as of July 1 of the previous year. These estimates represent annual average resident population rather than the population on that date.

a. Last Year's Accomplishments
/2009/The child death rate due to motor vehicle crashes (MVC) for children <= 14 per 100,000 saw a slight increase from 4.7 in 2005 to 5.0 in 2006, which is a 6.4% increase. However, the rate for each year is still lower than the rate of 5.5 from calendar year 2004. The total number of deaths to children <=14 years old due to MVC for calendar year 2006 was 90. Local Child Fatality Prevention Teams (CFPTs), found in each of the 100 counties in NC, have been reviewing the deaths of children ages 0 -- 17 for over ten years and reviewed all 90 cases of child deaths in 2006.

During 2006, 45% of local CFPTs provided educational programs on motor vehicle safety which is a 12% increase from 2005. In addition, 32% of local CFPTs that distributed car seats to low and no income residents in their counties. The Catawba County CFPT sponsored a presentation by the Catawba County Sheriff's Office to the child fatality and child protection team about teen driving and driver's education programs available to teenagers. This presentation led to meeting with local school officials about improving driver's education and sending a letter to the NC Insurance Commission regarding the idea of "pro-rating" insurance fees for teenagers who participate in defensive driving classes. The local team partnered with Catawba Safe Kids Coalition to form a community Teen Driving Committee to continue to research this topic and other topics about motor vehicle safety. Wilson County provided information to their community about motor vehicle safety via a newspaper article about the work of the local team and statistics on child deaths due to MVC in their county. They also held a MV safety program at their local high school which included a show of the Governor's Highway Safety Program's "crash car." Guilford County also focused their energy in 2006 on teen driving and motor vehicle safety by recommending the NC Graduated Driver's License law extend the period for limited passengers from six months to one year. Other county accomplishments in the area of MVC safety came from Halifax County. This county distributes car seats to their maternity patients as incentives to keep their appointments. They also have two employees of the local health department who are certified by the National Standard Child Passenger Safety Training Program who instruct all maternity patients on how to properly put safety seats in their vehicles.

During FY07, the North Carolina Child Fatality Task Force (CFTF), a legislative study commission, studied child deaths caused by motor vehicle injuries. The CFTF successfully recommended that the NC General Assembly strengthen the NC Child Passenger Safety law to eliminate an exemption that allowed a child to be out of his/her car seat when his/her "personal needs were being attended to." The amendment, which was successfully passed, also qualified North Carolina for National Highway Traffic Safety Administration funds which are being used to provide free or low cost child safety seats to families in need and to provide training for child passenger safety technicians who educate families on proper installation and use of safety seats. In addition, the CFPT worked to strengthen the All-Terrain safety law to expand safety training opportunities.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued review of child deaths due to motor vehicle crashes on the state and local levels.				X
2. CFTF advocates for new legislation aimed at preventing child deaths from motor vehicle crashes.				X
3. Community car seat distribution programs.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/ The Child Fatality Task Force, a legislative study commission, is reviewing data, trends, and best-practices that will increase motor vehicle safety in preparation for the next session of the NC General Assembly. Some of the issues being considered are: (1) strengthening the law that regulates passengers riding in the back of pick-up trucks, (2) providing decals that would be used voluntarily and would identify drivers in the Graduated Driver's License system so that others on the road would be more cautious and patient, (3) increasing the volunteer pool of child passenger safety technicians who provide instruction on installation of car seats by creating a Good Samaritan laws so they could not be held liable in the event of a crash or product malfunction, and (4) changing the orientation of the driver's license (from horizontal to vertical) for young drivers under age 21 to reduce illegal sale of alcohol to minors.//2009//

c. Plan for the Coming Year

/2009/In 2005 motor vehicle crashes were the second leading cause of death among children in NC (the first being natural deaths among infants). There were 163 child fatalities for children birth through 17 years old due to motor vehicle crashes in 2006. In FY09, the Child Fatality Task Force will continue to study ways to reduce motor vehicle fatalities among children by working closely with research partners and other experts to identify effective ways of preventing these types of deaths.//2009//

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				15.5	15.5
Annual Indicator			15.0	15.5	16.2
Numerator			11570	12379	13692
Denominator			76949	80019	84574
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16.5	16.5	17	17.5	17.5

Notes - 2007
Data are for CY06. CY07 data will be available in March 2009. Calendar year data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

Notes - 2006
Data are for CY05. CY06 data will be available in March 2008. Calendar year data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

Notes - 2005
Data are for CY04. CY05 data will be available in March 2007. Calendar year data are delayed almost a year and a half due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

a. Last Year's Accomplishments
/2009/The rate of breastfeeding initiation among mothers participating in WIC has increased from 48% in FY06 to 52.3% in FY07. The six month breastfeeding duration rate increased from 15.5% for CY05 to 16.2% for CY06.

Activities undertaken in FY07 to further increase breastfeeding rates included:
-Co-sponsoring the NC Lactation Educator Training Program (NCLETP) which was offered twice during the year (66 attendees);
-hosting the bi-annual WIC Program Breastfeeding Coordinator's Meeting
-distributing hospital grade electric and manual breast pumps and pump kits based on the indicated needs of local WIC agencies;
-conducting a free-of-charge Vitamin D (Tri-Vi-Sol Vitamins A, C & D) drops distribution program for infants who are exclusively breastfeeding
-providing professional resources and client educational materials to local WIC agencies;
-promoting World Breastfeeding Week activities around theme: "Welcome Baby Softly"
-providing continuation funding and training to the 23 local WIC programs with Loving Support Breastfeeding Peer Counselor Programs;
-distribution and promoting the implementation of activities included in the breastfeeding state plan "Promoting, Protecting and Supporting Breastfeeding: A North Carolina Blueprint for Action";
-providing continuation funding and support to the three Regional WIC Lactation Resource and Training Centers;
-supporting accurate breastfeeding data collection and analysis;
-filling the State Breastfeeding Peer Counselor Program Coordinator position;
-filling the State Breastfeeding Coordinator Position; and
- providing technical assistance to the Breastfeeding Workgroup for the Child Fatality Task Force.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support the efforts of Breastfeeding Peer Counselor Programs.		X		
2. Promote and recognize World Breastfeeding Week annually.			X	

3. Offer the North Carolina Lactation Educator Training Program two times a year.				X
4. Distribute electric & manual breast pumps and accessory kits to local WIC agencies throughout the state.		X		
5. Enhance and support accurate breastfeeding data collection and analysis.				X
6. Maintain a free-of-charge Vitamin D program for infants who are >= 6 weeks and mostly breastfeeding.		X		
7. Assure local agency public health staff receive training in breastfeeding support & lactation management				X
8. Offer training and consultation targeted toward childcare industry on breastfeeding and pumped breastmilk.				X
9. Distribute & promote a North Carolina plan for promoting, protecting and supporting breastfeeding.				X
10.				

b. Current Activities

/2009/ FY08 activities included:
-funding a $10,000 mini-grant to each of the 6 perinatal regions to implement breastfeeding promotion activities;
-developing a statewide awards systems plan to assist hospital partners (NC Hospital Association) to become breastfeeding friendly;
-revising materials for the NCLETP;
-collaborating with the Healthy Start Foundation SIDS Risk Reduction campaign to create a PSA promoting breastfeeding;
-working on a breastfeeding awareness article with members of the NC Pediatric Society and NC Academy of Family Physicians;
-developing collateral materials for the NC Breastfeeding Blueprint; and
-developing recommendations for the Child Fatality Task Force to advocate for breastfeeding at the legislative level.

WCHS continued these activities in FY08:
-co-sponsored the NCLETP (44 enrollees);
-distributed hospital grade electric and manual breast pumps and pump kits based on needs of local WIC agencies;
-promoted implementation of activities in the state plan;
-conduct a free Vitamin D drops distribution program for infants who are exclusively breastfeeding;
-provided professional resources and client educational materials to local WIC agencies;
-promoted World Breastfeeding Week;
-enhanced existing local WIC Program breastfeeding peer counselor programs;
-support accurate breastfeeding data collection and analysis;
-promoted breastfeeding support activities in child care agencies; and
-enhanced existing Regional WIC Lactation Resource and Training Centers.//2009//

c. Plan for the Coming Year

/2009/New activities planned for FY09 to promote and support breastfeeding duration include:
-developing an annual one-day lactation management update for previous attendees of NCLETP
-collaborating with the North Carolina Breastfeeding Coalition to build a statewide infrastructure for breastfeeding support;
-expanding the number of Regional WIC Lactation Resource and Training Centers;
-revising materials and activities related to the promotion of breastfeeding-friendly

workplaces;
-revising materials and activities related to promotion of breastfeeding in the child care setting;
-developing and distributing a self-study manual on "Breastfeeding Pumps Issuance and Loaning Guidelines" to local WIC agencies;
-promoting breastfeeding awareness with NC health care providers through collaborations with the NC Academy of Pediatrics and the NC Academy of Family Physicians; and
-collaborating with the NC Child Fatality Task Force to implement breastfeeding support recommendations for workplace policy and a statewide campaign.

Continuing activities in FY09 to promote and support breastfeeding include:
-co-sponsoring the NCLETP twice;
- promoting implementation of activities included in the breastfeeding state plan "Promoting, Protecting and Supporting Breastfeeding: A North Carolina Blueprint for Action";
-conducting a free-of-charge Vitamin D (Tri-Vi-Sol Vitamins A, C & D) drops distribution program for infants who are exclusively breastfeeding;
-promoting World Breastfeeding Week;
-supporting accurate breastfeeding data collection and analysis;
-promoting breastfeeding support activities in child care agencies;
-distributing additional hospital grade electric and manual breast pumps and pump kits based on indicated needs of local WIC agencies;
-providing professional resources and client educational materials to local WIC agencies;
-enhancing existing local WIC Program breastfeeding peer counselor program; and
-supporting and enhancing the existing Regional WIC Lactation Resource and Training Centers.//2009//

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	95	99	90	90	97
Annual Indicator	87.6	87.8	87.4	96.8	94.6
Numerator	102988	103985	106880	119164	123107
Denominator	117501	118493	122274	123045	130067
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	97	98	98	98	98

Notes - 2007
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based

on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth.

Notes - 2006
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth. The marked increase in the reported NPM data to 96.8% (up from 87.4%) is due to this change in the definition of “before hospital discharge.”

Notes - 2005
Universal newborn hearing screening program was implemented in calendar year 2000.

FY data are actually from the previous calendar (e.g., FY03 data is really CY02). The denominator is provided by the State Laboratory and the denominator for resident live births differs somewhat from the denominator used in outcome measures and other performance measures where the data are obtained from Vital Records.

Although NC had previously reported that over 99% of infants born in the state receive newborn hearing screenings prior to discharge from the birthing facility (an over reporting), a more sophisticated statistical analysis strategy was implemented in FY05 and used on current and past data and the procedures will be applied to data analysis plans in the future. Data for 2000, 2001, and 2003 have been updated using the new methodology.

a. Last Year's Accomplishments
/2009/There were 89 hospitals/birthing facilities in North Carolina providing newborn hearing screening. Data from the Hearing Link (HL), North Carolina's web-based data entry system, for calendar year 2006 indicated:
-Live Births (in HL) = 130,067
-Total Screened = 127,773
-Total % Screened (regardless of age) = 98.2% of the live births
-Total Screened by 1 month of age = 123,107
-Total % Screened by 1 month of age = 94.6% of the live births (or 96.3% of babies screened) were screened for hearing loss before leaving the birthing facility. Note - Prior to 2005, "before hospital discharge" was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of "before hospital discharge" was changed to include all babies screened for hearing loss within 30 days of birth.

HL was implemented in ten additional hospitals, bringing the total to 26 hospitals using the system. All hospitals on HL are trained to do direct data entry for demographic information and hearing screening results. The HL was used to determine data for the most recent (calendar year 2006) Hearing Screening and Follow-up Data Report for CDC, and is now able to provide data on the number of babies screened and the percentage that pass or refer on a hospital-by-hospital basis.

The child health speech and audiology consultants provide ongoing technical assistance, consultation, and support to hospitals and local providers. The hospital checklist is used by the speech and hearing team to insure that hospitals are running efficient programs. Gradually hospitals are transitioning to completing Program Plans rather than having consultants do checklists.

The Early Hearing Detection and Intervention (EHDI) Advisory Committee met quarterly.

Members continued to provide suggestions for program development and improvement.

A new Program Manager was hired and began working in February 2007, following a nationwide search.

Tympanometer/audiometers were purchased for 90 local health departments and were distributed in May 2007. Training was provided by Child Health Audiology Consultants to ensure proper use of the equipment.

Otoacoustic emission (OAE) screening was conducted by nurses in local health departments. Child health speech and hearing consultants developed a PowerPoint presentation to provide refresher training to these nurses. For nurses joining health departments, presentations covering protocols for otoacoustic emissions and tympanometry were provided twice at semi-annual orientation trainings.

The Project Coordinator for the MCHB grant "Monitoring Children with Hearing Loss in a Medical Home" identified twelve physician practices interested in participating in the project. Educational materials for parents and physicians were provided, and there were monthly conference calls to answer questions posed by the physicians or their staff members. Each practice was provided an OAE machine and had training in the use of the equipment. They were asked to log the hearing screenings that were completed through March 2008. One practice found a child with a unilateral sensorineural hearing loss as the result of this project.

Multiple responsibilities of regional consultant staff were creating a backlog in tracking infants identified by the program. A position was reallocated, and a person was employed in June 2007 to focus only on central tracking and the backlog. As the speech consultants have less responsibility for tracking, they have started to provide support to families whose children need to have audiological evaluations //2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancements to the Newborn Hearing Screening Data Tracking and Surveillance System.			X	
2. Technical support to the local newborn hearing screening programs in birthing/neonatal facilities.				X
3. Identification of needs and training opportunities for pediatric audiologists.				X
4. Regional staff assuring that all infants have access to screen and rescreen.		X		
5. Infants tracked through the screening, evaluation, and amplification process to assure no children missed.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/All birthing hospitals continue to implement their newborn hearing screening programs. Fifty-six hospitals now provide outpatient rescreens and several other hospitals are developing similar protocols.

Two additional hospitals and six audiology offices were trained to use HL. A system to keep track of needed upgrades to HL is in place, and a CDC grant application was submitted to help support these improvements.

The EHDI Advisory Committee continues to meet. Parents of underrepresented groups have been invited to become members. A 2-day statewide NC EHDI Conference was held in October 2007 with 125 participants.

One audiology consultant and the Program Manager attended the EHDI Family Support Conference in October 2007. They are now working with the Advisory Committee to organize an information sharing meeting with organizations that provide family support to parents whose children are deaf or hard of hearing.

Speech and hearing consultants continued to review Assistive Technology (AT) funding requests through December 2007, when an organizational change occurred, moving most AT funding to the EI Branch. Consultants provided support to local audiologists during the transition.

Eighteen audiologists, including the child health audiology consultants, attended the Auditory Evaluation for Infants Referred from Newborn Hearing Screening course.

Transition to central tracking continues. A position was added, and central tracking staff does tracking for 45 counties.//2009//

c. Plan for the Coming Year

/2009/In the coming year, hospitals will continue their newborn hearing screening programs. Most of the hospitals are expected to assume the responsibility for rescreens of infants who do not pass the initial hearing screening. Regional child health consultants will continue to provide ongoing support to hospitals and in-services about newborn hearing screening will be offered. Regional meetings will be held where key hearing screening personnel will be invited and will have the opportunity to learn from one another.

Training for hospitals to use Hearing Link will continue. Several new hospitals have expressed an interest in Hearing Link, and have completed statements of interest. Letters of agreement have been sent to the hospitals, and a preliminary meeting conducted or scheduled to outline the support and training their staff will receive from the speech and hearing consultants. When training is complete, these hospitals will use the Hearing Link for direct data entry of hearing screening results. Each birthing facility will receive an instruction manual, a printer, and a barcode scanner to utilize when they begin using Hearing Link. User IDs and passwords will be created for identified staff. Additional hospitals will be systematically trained until all birthing facilities are able to use Hearing Link to report initial hearing screening results and to generate hospital-specific reports. Development of an updated version of Hearing Link should be completed in 2009. It will include enhancements to make the system more user friendly with a diagnostic page that private providers can use to enter diagnostic and amplification hearing results directly into the Hearing Link database.

Regional child health audiology consultants will continue to provide training for local health department staff to use otoacoustic emissions for hearing screening, and tympanometry for suspected otitis media. Additional tympanometer/audiometers have been ordered for local health departments or districts that have more than one site. The equipment will be delivered, and training will be provided for the staff. CEUs are awarded to training participants.

With additional staff anticipated to be available through the CDC cooperative agreement, the central tracking staff will increase. Their activities will cover all 100 counties in the state, and will focus on quality assurance for the EHDI Program.

The EHDI Advisory Committee will continue with subcommittees that address specific issues. These committees will provide ongoing guidance in the implementation and evaluation of the program.

The national Family Support Conference will be held in North Carolina in October 2008. All the speech and hearing consultants will attend to gather new information and ideas about the types of support families need when they have a child with hearing loss. Consultants provide assistance for family support groups meeting statewide.//2009//

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	9	9	10	10	10
Annual Indicator	12.3	12.8	12.0	11.6	13.1
Numerator	267020	276660	266980	266110	302690
Denominator	2177890	2156720	2231120	2299390	2314354
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	10	10	10	10	10

Notes - 2007
FY07Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2006 and 2007 Current Population Surveys for children <18. (CPS: Annual Social and Economic Supplements).

Notes - 2006
FY06 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2005 and 2006 Current Population Surveys for children <18. (CPS: Annual Social and Economic Supplements).

Notes - 2005
FY05 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2004 and 2005 Current Population Surveys for children <18.

a. Last Year's Accomplishments
/2009/By March 31, 2007, 111,656 children were enrolled in the State Children's Health Insurance Program, NC Health Choice (NCHC). An additional 298,417 children had been enrolled in North Carolina's Children's Medicaid Program, Health Check (HC), since NCHC began in FY99, including 38,993 children 0-5 who qualified for NCHC, but who now qualify

for Medicaid. 2004-05 CPS data indicate 11.6% of children <=18 years old in NC remained uninsured (a 3% drop). Medicaid eligibility processing times have increased with new Deficit Reduction Act requirements to document citizenship and identity. Analysis prepared for a NC Emerging Issues Forum held in 2005 concluded that "the growth (in the number of North Carolinians without health insurance) is the result of a significant decline in employer-sponsored insurance. The 2001 recession and weaker-than-expected job growth in subsequent years has led to the erosion of health insurance coverage, especially among small businesses."

Highlighted FY07 activities include:
-Disseminated information including bilingual tools concerning new citizenship and identity requirements to broad-based list serves.
-Focused on infrastructure development to assure access to health insurance and quality medical homes. As a result of policy development and training, all ESC offices, Juvenile Justice Court counselors, and More-at-Four staff have incorporated outreach activities into their job functions. Smart Start (0-5) / Pre-K Standards and School Readiness Indicators address these issues. About 880,000 Health Check/NC Health Choice (HC/NCHC) materials were distributed (>2X increase).
-Worked closely with trusted refugee/minority leaders on outreach through their festivals, businesses, churches, shamans, etc. The C&Y Branch's relationship with the Hmong community has been strengthened by their involvement in Branch cultural orientation and work planning. Relationships with the Montagnard and Vietnamese communities are evolving.
-The launch of the "Choosing a Quality Medical Home" bookmark was carried out.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain HC/NCHC Outreach Campaign in partnership with the NC Healthy Start Foundation.			X	
2. Maintain a bilingual NC Family Health Resource Line that offers information, referrals and advocacy.			X	
3. Maintain HC/NCHC Outreach Web Site as a one-stop-shop for outreach workers.			X	
4. Maintain HC/NCHC education campaign “The Right Call Every Time” to promote use of a medical home for preventive & primary care and to reduce inappropriate ER use.			X	
5. Continue to develop Medical Home education campaign for children with special health care needs.			X	
6. Simplification of enrollment/re-enrollment forms and continued development of family-friendly notices.		X		
7. Development of comparable data sets for HC and NCHC.				X
8. Targeted outreach to special populations (including minority and CSHCN).			X	
9. Development of infrastructure to promote and sustain HC/NCHC outreach.				X
10.				

b. Current Activities
/2009/By 3/31/2008, 119,963 children were enrolled in NCHC and 750,354 children were enrolled in HC. 2005-06 CPS data indicate 13.1% of children <=18 years old remain uninsured. Plans to insure more children were impacted by the August 2007 CMS Memo preventing NC from implementing an SCHIP expansion to 300% FPL and failure to pass

SCHIP reauthorization, blocking increased federal funding for SCHIP outreach/enrollment.

The state outreach coalition developed a Strategic Plan guiding work in FY08:
- Developed infrastructure with new outreach partners: VITA Centers; those who market tax credits; Connect Inc. (state resource for job placement, etc.); Community College System; Human Resource Development (HRD) Associations; Summer Food Program; and new NC-PTA leadership.
-Nurtured existing partnerships.
-Advocated to reduce barriers for families enrolling in HC/NCHC.
-Targeted outreach to American Indian, Black; Latino; Refugee and CSHCN. HC/NCHC Fact Sheets developed for 5 limited English proficient (LEP) populations (Arabic; Chinese; Korean; Montagnard; Vietnamese).
-New quarterly data reported to help monitor/respond to trends.
-Web development included "news" updates; links to/from external web sites; and "Partnership Page" with links to online training, materials catalog/order form, directories of local DSSs/outreach staff.
-HC/NCHC Campaign produced press releases, newsletter articles, English/Spanish TV/Radio PSAs; and DVDs of Medical Home Stories.//2009//

c. Plan for the Coming Year

/2009/The number of uninsured children in NC continues to grow despite increased enrollment in Health Check and Health Choice. Analysis by Elise Gould of the Economic Policy Institute in November 2007 found that employer-provided health insurance coverage for children under 18 years old in NC decreased by 7.8 percentage points to 55.5% between 2000-01 and 2005-06.

To respond to the increased numbers of uninsured children and the changing demographic characteristics of the uninsured, the NC Coalition to Promote Health Insurance for Children held a Strategic Planning Session in June 2007, staffed and facilitated the C&Y Branch. Based on that Strategic Plan, the priorities that will continue to guide the Branch's work include:
-Infrastructure development to assure access to health insurance and a quality medical home. A focus will be new creative approaches for doing HC/NCHC outreach through schools. The School Health Subcommittee of the state coalition is leading this effort. A focal point is the CDC-Funded Coordinated School Health Program and their School Health Advisory Councils (SHACs). A menu of activities is being developed for SHACs to consider in doing outreach on the local level. Pilot projects are planned. Other priorities include working with the Department of Insurance on a requirement to share information about HC/NCHC with families who lose employer-sponsored coverage; encouraging insurance agents and small business employers to offer HC/NCHC when families cannot afford private coverage; and working with families in transition to obtain needed services (e.g. Family Support Programs/Toll-Free Lines on Military Bases who assist families transitioning out of the military).
-Continued nurturance of existing partnerships with schools, child care centers, pre-Kindergarten programs, health providers, ESC offices, Department of Juvenile Justice and Delinquency Prevention court counselors, HRD associations, community colleges, etc.
-Advocacy to promote policies that reduce barriers for families to enroll/re-enroll in HC/NCHC. Ideas to explore include creating an easy point for verification of income (e.g. state tax return) and piloting a single portal of entry for public assistance using an electronic kiosk.
-Targeted outreach to special populations including CSHCN, minority and refugee populations. One focus will be strengthening relationships with individuals/CBOs in the 5 LEP communities for whom we have developed newly-translated HC/NCHC fact sheets.
-Continue to develop data reporting that supports Branch efforts to monitor/respond to

trends.
-Continued HC/NCHC and Medical Home Campaign Development including web-based, electronic and print media.//2009//

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				25	25
Annual Indicator			30.1	29.3	30.4
Numerator			20837	23750	27491
Denominator			69138	80955	90390
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	25	25	25	25	25

Notes - 2007
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

Notes - 2006
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

Notes - 2005
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

a. Last Year's Accomplishments
/2009/During FY07, activities undertaken by the C&Y Branch and the NSB to promote healthy weights among children 2-5 years of age included:

- promoting the utilization of Medicaid funded Medical Nutrition Therapy (MNT) services for children;
- coordinating with the Expanded Food and Nutrition Education Program (EFNEP) to implement "Families Eating Smart, Moving More" group education modules in public health departments and WIC agencies;
- introducing new client nutrition and physical activity education materials;
- identifying young children at-risk for overweight and providing nutrition education and counseling;
- developing a Value-Enhanced Nutrition Assessment (VENA) which addresses/impacts WIC policies, practices, training and guidance;
- educating parents, caregivers, and young children themselves on healthy nutrition and physical activity behaviors; and
- continuing the use of NC-NPASS data to monitor trends in overweight among children.

Additional information regarding this National Performance Measure can be found in the narrative for State Performance Measure #3 - Percent of children 2-18 who are overweight.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancement of Nutrition and Physical Activity Surveillance System (NC-NPASS).				X
2. Education of health care professionals/staff training.				X
3. Education of children and their parents/caretakers.	X			
4. Continuation and expansion of Nutrition and Physical Activity Self Assessment for Child Care.				X
5. Implement WIC program policies supportive of dietary change.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2009/In FY08, activities undertaken to promote healthy weights among children 2-5 years of age include:
- offering training to public health nutrition staff on motivational interviewing;
- implementing changes to the WIC food package which could help promote healthy weights in children (i.e., reducing the amount of juice offered);
- implementing the VENA plan to incorporate VENA principles into WIC policies, practices, training and guidance;
- developing an on-line Pediatric Nutrition Course for local agency nutritionists working with WIC participants;
- implementing an Obesity Prevention Tool kit for child care centers; and
- developing tool kits for "WIC mini nutrition education lessons" for preschool education.

Continuing activities for FY08 include:
- promoting utilization of Medicaid funded MNT services for children;
- using NC-NPASS data to monitor trends in overweight among children; and
- introducing new client nutrition and physical activity education materials.//2009//

c. Plan for the Coming Year

/2009/New activities planned for FY09 to promote healthy weights among children 2-5 years of age include:

- implementing the new WIC Program food packages which will help promote healthy weights and educational materials relevant to the changes; and

- implementing a low fat milk educational campaign.

Continuing activities for FY09 include:

- promoting utilization of Medicaid funded MNT services for children;

- offering training to public health nutrition staff on motivational interviewing;

- using NC-NPASS data to monitor trends in overweight among children; and

- implementing VENA activities.//2009//

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				12	12
Annual Indicator			12.5	12.1	11.5
Numerator			14959	14839	14668
Denominator			119773	123040	127646
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11	10	10	10	10

Notes - 2007

Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here is CY06 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

Notes - 2006

Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here is CY05 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

Notes - 2005

Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here is CY04 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data.

The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

a. Last Year's Accomplishments

/2009/An ad hoc committee of Women and Tobacco Coalition for Health (WATCH) updated the "Guide for Counseling Women Who Smoke" and the companion video, Counseling From the Heart. This is the third revision of the guide. It is distributed to local health departments, community health centers, private practices, and community-based organizations throughout NC as part of the training initiative.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update and distribute The Guide for Counseling Women Who Smoke and other educational materials.			X	
2. Facilitate and manage the Women and Tobacco Coalition for Health activities.				X
3. Develop/sustain partnerships with women's health and tobacco use prevention/cessation organizations.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/WATCH provided input in the revision of two educational brochures published by the NC Healthy Start Foundation -- If You are Pregnant and Smoke and Oh Baby! We Want to Keep You Safe From Secondhand Smoke.

Perinatal Outreach Coordinators continue to provide smoking cessation training to perinatal healthcare providers in local health departments, community-based organizations, private practices, and other sites.

WATCH continues working on a plan to address postpartum smoking relapse, including development of a hospital packet on postpartum relapse and building relationships with hospitals.

The "Guide For Counseling Women Who Smoke" has been posted on the Internet via the Division of Public Health -- Women's Health Branch webpage at the following url: http://whb.ncpublichealth.com/provPart/pubmanbro.htm. Click on Manuals to find this guide.//2009//

c. Plan for the Coming Year

/2009/Training on the office-based system for tobacco cessation counseling for local health department use will be provided during FY09.

In addition, WATCH continues to pursue Medicaid reimbursement for tobacco cessation counseling.//2009//

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5	5	6	6	6
Annual Indicator	5.2	7.4	7.3	6.5	6.8
Numerator	30	43	43	39	42
Denominator	572740	581841	592645	602355	621709
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6	6	6	6	6

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

Notes - 2006
FY year data are actually the prior calendar year, e.g. FY06 is really CY05.

Notes - 2005
FY year data are actually the prior calendar year, e.g. FY05 is really CY04.

a. Last Year's Accomplishments
/2009/The rate of deaths due to suicide for children 15-19 in 2006 was 6.8 which is a slight increase of 4.6% from the 2005 rate of 6.5. The total number of deaths within the population of 621,709 was 42 compared to 39 deaths within a population of 602, 355 for 2005.

The North Carolina Youth Suicide Prevention Task Force (YSPTF), led by staff from the Injury and Violence Prevention Branch of the NC DPH, has provided a forum for studying the problem of youth suicide in North Carolina, collaboratively conducting activities, and developing a state plan. The task force applied for Garret Lee Smith Memorial funding in 2007 but did not receive any funds.

Suicide prevention activities that continued during the unfunded period included:
1) suicide awareness presentations at health fairs, professional conferences, and for community groups
2) suicide intervention training and suicide symptom recognition training
3) Child Fatality Prevention Team Conference break-out session on youth suicide prevention
4) networking with the Triangle Consortium for Suicide Prevention including participation in a suicide awareness walk.

Additionally, North Carolina's Violent Death Reporting System (NC-VDRS) continued to refine and advance data collection of suicide deaths and hospitalizations. The YSPTF responds to requests for data from community groups and media to illustrate the issue of

suicide in order to promote support for prevention.

The NC House Bill (H718) that would have appointed an Advisory Board and allocated funds for developing a suicide prevention awareness campaign was referred to the Committee on Appropriations in March 2007, but no further action was taken during the long session of the 2007 NC General Assembly.

The North Carolina Child Fatality Task Force supported efforts of the Injury and Violence Prevention Branch to attain funding for youth suicide prevention by assisting with grant applications. The Office of the Local Child Fatality Prevention Teams also supported these efforts by participating on the YSPTF and reviewing grant applications.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. C&Y Staff serve on the North Carolina Youth Suicide Prevention Task Force (YSPTF) and participate in its activities.				X
2. The CFTF advocates at the legislative level for recommendations made by the YSPTF.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/The NC YSPTF re-applied for Garrett Lee Smith Memorial funding which was released for the third time. The YSPTF modified the application that they submitted the previous year to account for service changes in the state, feedback from previous applications, and from review of grants from states that were funded. The application calls upon forming enhanced partnerships with Healthy Schools and the school-based/school-linked health centers.

Members of the YSPTF who also serve on the Triangle Consortium for Suicide Prevention (TCSP) promoted and participated in the second annual "Walk to Save a Life" awareness walk in downtown Chapel Hill This year the event was organized in conjunction with the American Foundation for Suicide Prevention. It raised $11,000 which will be used for local community efforts.

The Mental Health Association, with the feedback of the YSPTF, developed a suicide awareness addendum to be added to law enforcement training.

Area L AHEC asked a speaker from YSPTF to develop and present four workshops about depression/suicide prevention to their primary care and hospital physicians. Area L AHEC anticipates producing a podcast of the topic utilizing the speaker.

An organization in the Triad area is forming which is patterning itself after TCSP. TCSP is lending technical guidance and anticipates future collaboration across the regions. North Carolina passed a mental health parity law that is to become effective on July 1, 2008.//2009//

c. Plan for the Coming Year

/2009/ If received, the Garrett Lee Smith Memorial Grant will dictate the majority of activity of the YSPTF for FY09. Activities will include a communications awareness campaign, gatekeeper training, and an RFA process for school-based and school-linked health centers.

Response to communities' requests for data information and workshop speakers will continue regardless of whether the grant is received.

The Child Fatality Task Force will continue to partner with suicide prevention leaders in NC to address the needs of at risk-youth. The Office of the Local Child Fatality Prevention Teams will continue to support the efforts of the Injury and Violence Prevention Unit by serving on the YSPTF.

LivingWorks Training is still being conducted with support from the NC Mental Health Association.//2009//

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	83	83	83	83	83
Annual Indicator	78.1	80.2	79.2	79.9	78.2
Numerator	1447	1450	1542	1541	1559
Denominator	1852	1808	1946	1929	1993
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	83	83	83	83	83

Notes - 2007

These data include deliveries at 12 facilities originally designated for high-risk deliveries and neonates back in the 1980s. There are other hospitals within the state with NICUs whose deliveries are not included in this count.

FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

Notes - 2005

These data include deliveries at 12 facilities originally designated for high-risk deliveries and neonates back in the 1980s. There are other hospitals within the state with NICUs whose deliveries are not included in this count.

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

a. Last Year's Accomplishments

/2009/The Neonatal Outreach and Education Trainers (NOETs) and Perinatal Outreach and Education Trainers (POETs) continue to educate providers on the Neonatal Bed Locator

Service and other issues of importance regarding very low birth weight infants born in tertiary centers. During FY07, over 2,487 health care and human service providers from across the state received training through this program. Needs assessments were conducted to determine clinical educational needs. From these assessments, 127 training sessions were completed totaling 526.4 hours of training.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implementation of contract with Wake Forest University for Neonatal Bed Locator services.				X
2. Continual review of data to access sites more likely to keep low birthweight babies.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/The NOETs continued to provide training to hospital neonatal and pediatric staff on Newborn Convalescent Care and Discharge Planning (>10 trainings) and Resuscitation and Stabilization (>40 trainings).//2009//

c. Plan for the Coming Year

/2009/For the upcoming fiscal year, the NOETs will continue a priority focus on neonates and infants recovering from critical conditions of the newborn period. This will include intensive focus on resuscitation and stabilization and developmental care.//2009//

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	87	87	87	87	87
Annual Indicator	83.7	83.7	83.3	82.7	81.9
Numerator	98226	99039	99822	101716	104528
Denominator	117307	118292	119773	123040	127646
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	87	87	87	87	87

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

Notes - 2006
FY year data are actually the prior calendar year, e.g. FY06 is really CY05.

Notes - 2005
FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

a. Last Year's Accomplishments
/2009/ Assuring ongoing provision of prenatal case management services to low-income women, including assistance with facilitating early access to prenatal care and addressing barriers to entry to care, remains a high priority of the Perinatal Health and Family Support Unit of the Women's Health Branch.

The First Step Campaign continued to promote the MCH Hotline, called the NC Family Health Resource Line (NC FHRL), through information and referral and encouraged women to seek early and continuous prenatal care services. First Step campaign activities focused on African American and American Indian communities, outreach to Latinos, and on the following topics: prematurity and low birthweight issues, evidence-based practices on disparity in perinatal health, and awareness of safe sleep practices. Educational and promotional materials which address the impact of infant mortality, racial disparity, low birthweight, and prematurity on families and the state were developed and narrowed in focus. In conjunction with the March of Dimes and N.C. Folic Acid Council, educational information and materials were distributed that promote good health during women's childbearing years and raise awareness of consuming folic acid as a way to reduce birth defects. The Back to Sleep Campaign (BTS) promoted Sudden Infant Death Syndrome (SIDS) awareness and risk reduction practices targeting African American and Latino parents and childcare providers. Activities relating to raising awareness of the dangers of smoking and secondhand smoke were continued.

Thirteen Healthy Beginnings (minority infant mortality reduction program) sites served 731 pregnant women in FY07. Of the 480 babies born to these women, 53 were of low birth weight, and there were 3 infant deaths. Wrap-around services (education, transportation, group counseling, housing, etc.) continued to be offered to support mothers and young families as they begin their journeys into parenthood.

The Perinatal Depression workgroup was formed in order to consider ways to address perinatal depression in North Carolina. The goals of the workgroup are based on the five recommendations from a 2005 report by Onunaku at the National Center for Infant and Early Childhood Health Policy at UCLA: 1) increase maternal depression awareness to providers in the health care community, early care and education, and family support; 2) perform outreach and education to expectant and new mothers to address stigma and patient barriers; 3) assure earlier identification of maternal depression in health care settings by addressing barriers to recognition, screening, assessment, and referral; 4) invest in evidence-based interventions that improve the mother-child relationship; and 5) build a comprehensive network of community perinatal service providers to strengthen mental health in the pregnant and postpartum family. A review of the literature was done, and national and state depression prevalence data was gathered.

The Baby Love Plus program continued to conduct provider training focused on cultural competency and customer service. Several Family Leadership Development Retreats were held in order to provide families and community participants additional skill building opportunities.//2009//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maternity Care Coordination and Maternal Outreach Worker programs ongoing.		X		
2. Re-application process for Minority Infant Mortality Reduction (Healthy Beginning) Projects.				X
3. Continued outreach through Baby Love Plus with a focus on perinatal women's health.		X		
4. Work with Sickle Cell Program to educate families of childbearing age on perinatal health issues.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/The NC Healthy Start Foundation continues to promote the NC FHRL and First Step campaign activities focusing on African-American and American Indian communities and outreach to Latinos.

Four of the Healthy Beginnings sites have Lay Health Advisor (LHA) Programs to help young parents adjust to the challenges of parenthood. The LHAs are trained in environmental smoking elimination, SIDS education, breastfeeding promotion, and other parenting skills. Eight planning sites were funding in the hopes of funding some of them at the implementation level in the future. There are 9 current implementation sites.

The Perinatal Depression workgroup is developing a needs assessment survey to be administered to providers of pregnant and postpartum women. The group continues to look to other states for their lessons learned and successful approaches to recognizing and treating perinatal depression.

The maternal health program implemented an improved data collection system for recipients of prenatal case management services including intake and outcome data to track gestational age at entry to prenatal case management and at entry to prenatal care.

After nearly three years, a Baby Love Plus Program Supervisor was hired. The Baby Love Plus program has designed a new data collection system in order to capture more program participant data and track trends over time. The Community Health Advocates have enhanced their focus on secondary outreach (program participant retention). //2009//

c. Plan for the Coming Year

/2009/The NC Healthy Start Foundation will continue to promote ways to improve the health of women of childbearing age and their families by the promotion of the NC Family Health Resource Line's information and referral service and First Step campaign activities focusing on African-American and American Indian communities and outreach to Latinos. A special focus area will include preconceptional and interconceptional care. Discussions and program design will focus on qualitative data and pregnancy intendedness. In conjunction with the March of Dimes and N.C. Folic Acid Council, educational information and materials will be distributed that promote good health during women's childbearing

years and raise awareness of consuming folic acid as a way to reduce birth defects. Qualitative data will be collected that informs the state about knowledge, beliefs, practices and healthcare access related to improving the health of Latino families. The Sickle Cell Campaign will continue to provide promotional materials and information to encourage individuals to know their trait status.

Healthy Beginnings plans to fund up to 5 new implementation sites to broaden reach and scope of the program. They will continue to offer skill buildings for implementation sites. Work will be done to strengthen the fatherhood initiative in several of the sites as fathers are encouraged to actively support their partners in both preconceptional and interconceptional health.

The Perinatal Depression Workgroup will implement the provider survey and interpret the results in the coming year. The workgroup will further look into ways of reimbursing depression treatment for the target group. Possible treatments which the group has focused on have been formal therapies such as cognitive behavioral therapy and interpersonal psychotherapy, which are both evidence-based and have been validated to decrease the symptoms of perinatal depression. Discussions will continue with Division of Mental Health, Substance Abuse, and Developmental Disabilities, along with the Division of Medical Assistance to strengthen treatment options for women of childbearing age.

Plans to expand reimbursable case management services to include outreach efforts to locate pregnant women as early as possible in their pregnancies to facilitate early entry to prenatal care will be explored during FY09. In addition, plans to increase awareness of the availability of prenatal case management services for low-income women through increased education and marketing to the private obstetrical community will be carried out, thus reducing potential barriers to early entry to prenatal care.

Baby Love Plus program sites will continue to use the revised data collection system to ensure timely reporting and follow-up for families. Training will center on interconceptional care issues.//2009//

D. State Performance Measures

State Performance Measure 1: *Number of children affected in substantiated reports of abuse and/or neglect as compared with previous years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	30000	30000	27000	27000	24000
Annual Indicator	30016	27310	26670	24597	14744
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14000	14000	14000	14000	14000

Notes - 2007
North Carolina has implemented the Multiple Response System (MRS) statewide. MRS is an effort to reform the entire continuum of child welfare in North Carolina- from intake through placement services. The goal of MRS is to bring services and supports more quickly to families

in need, called “frontloading”. Greater frontloading of services reduces the probability that a child would come back into the system within 6 months following an initial assessment finding services needed or a substantiation of abuse or neglect. In 2007 the recurrence of maltreatment did begin to decline by 27% (5.5% in SFY 2006-2007 as compared to 7.5% in 2001-2002).

MRS has changed many data definitions and therefore trend data on assessments and substantiations are not available. MRS allows a two pronged approach to CPS involvement: The Family Assessment Track and the Investigative Track. While the Investigative track is the “traditional approach”, which would lead to the unsubstantiation or substantiation of a case, the Family Assessment track does not. With the Family Assessment Track, families are found “in need of services”, “services recommended”, or “no services recommended”. In February 2006, the NC Division of Social Services added a new finding for Family Assessments, "Services Provided, No longer Needed." This finding indicates that the safety of a child and future risk of harm are no longer issues because the agency has been successful in frontloading necessary services during the family assessment and therefore the case was neither substantiated or “Services Needed”. As the Family Assessment Track of MRS can address neglect and dependency, some of the “Services Needed” reflects dependency allegations. (NC Division of Social Services, 2007).

Notes - 2006
Manual indicator (count) is used in this state performance measure.

Notes - 2005
Manual indicator (count) is used in this state performance measure.

a. Last Year's Accomplishments
/2009/The Parent Education Consultant (PEC) position was filled in FY07 and the PEC participated in increased fatherhood activities as well as served on the Fatherhood Advisory Council. The PEC began working with the Child Maltreatment Prevention Leadership Team (CMPLT) to increase efforts on parenting programs which will reduce child maltreatment. The PEC and the Executive Director (ED) of the CMPLT worked cooperatively with the NC Parenting Education Network (NC PEN) and provided training on evidence-base parenting programs at a NC PEN conference.

DPH remains the lead state agency in prevention of child maltreatment via the CMPLT located in the WCHS. The CMPLT emphasis is on: the implementation of evidence-based practices, influencing social norms to support healthy parenting and strong families, enhancement of service delivery to families, and increased funding for child maltreatment prevention services. The Task Force on Child Maltreatment Prevention was reconvened in November 2007 and reported that since the original Task Force report entitled New Directions was issued' progress has been made on 79% of the Task Force's recommendations. The CMPLT implemented and/or completed the following recommendations in 2007:
- Increased requirements among state level agencies in the use of evidence-based programs as a funding criterion (DPH, DSS, DPI, MH/DD/SAS, DCD, and NCPC).
- An RFA for the Nurse Family Partnership in NC for funding in 6-8 sites for 5-7 years. This initiative will be funded by DPH-WCHS, The Duke Endowment, and the Kate B. Reynolds Charitable Trust. Fifteen (15) local communities were invited to apply for funding. The planning process began in July 2007 to work with local communities to assess readiness for implementation of the Nurse Family Partnership.
- The Period of PURPLE Crying project is a joint project with the UNC-CH Injury Prevention Research Center, National Center on Shaken Baby Syndrome, and Center for Child and Family Health. This project's aim is to prevent child fatalities and child maltreatment through a public awareness campaign.
- The Early Childhood Comprehensive System (ECCS) initiative designed a collaborative decision making and action oriented group in the early childhood system, composed of

agency leaders.
- Parenting with Parents Training Initiative: NC Division of Child Development, in conjunction with the CMPLT and other key stakeholders, implemented a project to assist child care providers in working with parents and families to reduce their risk for child maltreatment.
- The CMPLT worked in collaboration with the Adolescent Parenting Program Project to review best practice.
- The CMPLT also began a number of projects that carried over into FY08, including development of a mortality surveillance system and development of a media plan through the FrameWorks Institute.

The ED of the Child Fatality Task Force (CFTF) participates on the Legislative Study Commission on Children and Youth, which convenes to study issues that include child abuse and neglect and serves on the Program Improvement Plan Committee for NC-Division of Social Services. The Child Fatality Task Force and CMPLT Executive Directors are members of the NC Pediatric Society Committee on Child Abuse and Neglect. They also both serve on the North Carolina System of Care Collaborative.

The Child Fatality Prevention Team (CFPT) continued to inform the public about NC's Safe Surrender Law through a Statewide Public Awareness Campaign. The Public Affairs Office (PAO) of DHHS implemented a $98,000 grant which included a radio public service announcement and printable Safe Surrender Information. CFPT also sent safe surrender posters, flyers and fact sheets in English and Spanish to community partners.

The Adolescent Parenting Program Project continued to provide funding to local communities.

The CFTF recommended strengthening criminal charges for "child endangerment," an act or omission on the part of a person supervising a juvenile under the age of 16 that demonstrates reckless disregard for the juvenile's life. The NC House and Senate considered this bill during the 2007 Session and it will be reintroduced in the 2008 session.

The CFTF worked on seeking clarification with the Attorney General's office on the child abuse and neglect reporting standards for physicians and hospitals. This work is being carried over to 2008.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued implementation of the Adolescent Parenting Program Projects.		X		
2. Continue training professionals and public awareness activities for the Infant Homicide Prevention Act.			X	
3. Assist with implementation of Task Force on Child Maltreatment Recommendations.				X
4. Expand the role of the Parenting Program Manager to be a focal point for prevention of CAN activities and expand the inclusion of fathers in planning, education and training.				X
5. Continue collaboration with NC Parenting Education Network.				X
6. Continue support of the NC Fatherhood Development Advisory Council.				X
7. Assist with the implementation of the Nurse Family				X

Partnership.				
8. Continue the development of the ECS Facilitation Team.				X
9.				
10.				

b. Current Activities

/2009/WCHS is developing a new team, the Every Child Succeeds (ECS) Facilitation Team, to address child maltreatment prevention which will include the PEC (position vacant since resignation of former PEC in July 2007) and staff from CFTF, CMPLT, ECCS Initiative. This new team will be a collaborative infrastructure which will allow DPH to pursue existing objectives relating to child maltreatment prevention more effectively.

The CFTF is working on the following: a revised bill to strengthening criminal charges for "child endangerment"; clarification on the child abuse and neglect reporting standards for physicians and hospitals; and studying the feasibility of a centralized 800 number reporting system for NC. Additionally, the CFTF and the CMPLT will work cooperatively to assess services for maternal depression including increased Medicaid coverage.

The CMPLT is working on the following: increasing the Nurse Family Partnership; development of a mortality surveillance system; development of a shared media message through the FrameWorks Institute; and increased funding for evidence-based parenting programs.

The CFPT will continue to provide Safe Surrender information to community partners as requested and, in collaboration with Child and Family Support Teams, make a report of findings and recommendations from the local Child Protection Teams to the NC-DSS.//2009//

c. Plan for the Coming Year

/2009/WCHS will continue the development of the ECS Facilitation Team, providing a collaborative infrastructure which will allow DPH to pursue and expand existing objectives relating to child maltreatment prevention more effectively, as well as engage other state and local partners in these efforts. By joining these individual initiatives into a collaborative process, DPH will be able to maximize resources which currently exist within WCHS without new resources. The engagement of the CFTF ED in this initiative will facilitate the ECS stakeholder access to the members of the Child Fatality Task Force. In turn, the CFTF will benefit by having a broader range of experts participating in the committees which research the CFTF interest and bring critical issues to the attention of the CFTF. The ECCS initiative participation in ECS brings substantial expertise in the critical issues of consensus indictor sets, childhood best practices, and interagency collaboration, as well as direct access to the early childhood programs decision-makers. The CMPLT executive director brings expertise in child maltreatment prevention activities and strong networking with many agencies represented on the Child Maltreatment Prevention Leadership Team. The Parenting Support lead will be deeply involved with the evidence-based, community-based family support initiatives in the state.

Through the new collaborative infrastructure, WCHS will continue to work toward the implementation of the recommendations in the New Directions report, as well as work toward the goals of the CFTF and the ECCS initiative. Work on the New Directions recommendations that commenced in FY07 will continue, with the addition of the following shared priorities and activities:

- Increased Medicaid coverage for post-partum women;
- A plan for addressing maternal depression screening and services;
- The use of shared indicators among multiple state agencies;

- Development of domestic violence screening and protocol for home-visitors;
- Increased use of evidence-based parenting programs and state level support to local communities to increase outcomes;
- Increased population-based sexual abuse prevention programs;
- Work with DSS to expand and strengthen universal/selective child maltreatment prevention efforts through the Multiple Response System (MRS);and
- Increased training/awareness on child abuse and neglect reporting laws (focus on health professionals and educators), including the feasibility of a centralized reporting system.

The WCHS will issue an RFA for evidence-based parenting programs and will work collaboratively with the Alliance for EBP to provide state level scaffolding to support local communities to increase model fidelity and program outcomes.

The CFPT will continue to provide Safe Surrender Workshops and educational materials to community partners as requested. Safe Surrender will continue to be a priority.//2009//

State Performance Measure 2: *The number of children in the State less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				13673	15040
Annual Indicator	10504	10978	12436	13673	15048
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	15500	15700	16000	16000	16000

Notes - 2007
Manual indicator (count) is used in this state performance measure.

Notes - 2006
Manual indicator (count) is used in this state performance measure.

Notes - 2005
Manual indicator (count) is used in this state performance measure.

a. Last Year's Accomplishments
/2009/The program received additional resources in FY06 and FY07 for provision of community based EI services and staff for the program's CDSAs to provide evaluation, service coordination, and EI services when no other appropriately qualified community based provider is available.

By the end of December 2006, all 18 CDSAs had achieved compliance in the 45 day timeline (from the date of referral of the child to the date that a service plan is in place if the child is eligible for the program). This indicator reflects the critical component of early intervention-the the provision of services as soon as possible when the child is identified with a special need.

Compliance was also achieved for transition of the child at his or her third birthday. Timeliness of services (defined as beginning services within 30 days of the service being

listed on the service plan) improved from 73% to 92%.

The state level and CDSA level monitoring systems were continued. Focused technical assistance to CDSAs resulted in increased performance with child find quality indicators.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued implementation of state level monitoring system				X
2. Collection of referral data on a monthly basis				X
3. Increase in number of enrolled children to 15, 500 in 2007-2008	X			
4. Development and implementation of State Performance Plan (SPP)				X
5. Public reporting on all data from SPP at local and state levels				X
6. Examination of and improvement in efficiency and effectiveness				X
7.				
8.				
9.				
10.				

b. Current Activities

/2009/Baseline data for children's developmental outcomes were collected in all CDSAs for children enrolled at least six months in the program. Entry data on the child is compared to the outcomes for the child at the time that he or she transitions out of the EI program. The outcome measures are the percent of infants and toddlers enrolled in EI who demonstrate improved positive social-emotional skills (including social relationships), acquisition and use of knowledge and skills (including early language/ communication), and use of appropriate behaviors to meet their needs.

Family outcome measures were collected through a nationally validated family survey to provide information on the percent of families participating in EI who report that EI services have helped the family know their rights, effectively communicate their children's needs, and help their children develop and learn.

Annual performance reports are completed regarding the six year State Performance Plan. This annual report is used by the federal granting agency to measure all states' and territories' EI programs through a series of "determinations." Programs were determined to meet requirements or to need various levels of technical assistance. The North Carolina program was listed at the mildest level of needing technical assistance, per increased compliance shown. Determination categories also were applied to each CDSA by the state level program.//2009//

c. Plan for the Coming Year

/2009/Goals for each CDSA and for the statewide determination are to "meet requirements". Per the State Performance Plan, a variety of compliance and performance indicators will continue to be addressed. Staff vacancy rates have decreased, and the program has an overall goal of less than 10% vacancy rate. Timeliness of services is expected to be met at the 100% level, and increased focus on child find efforts should

result in additional infants and toddlers being referred to and enrolled in the program. Data on child and family outcomes will continue to be collected. New requirements by the federal funder for fiscal monitoring will be implemented. Continued collaboration regarding Medicaid will be needed with proposed rule changes through the federal CMS agency for targeted case management, the billing activity identified for service coordination.//2009//

State Performance Measure 3: *Percent of children 2-18 who are overweight. Overweight is defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				15	14
Annual Indicator	15.6	16.5	17.0	16.7	17.4
Numerator	15820	16155	17394	19151	20062
Denominator	101184	98201	102480	114970	115394
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13	12	10	10	10

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

Notes - 2006
FY year data are actually the prior calendar year, e.g. FY06 is really CY05.

Notes - 2005
FY year data are actually the prior calendar year, e.g. FY03 is really CY02.

a. Last Year's Accomplishments
/2009/During FY07, activities undertaken by the C&Y Branch and NSB to promote healthy weights among children 2-18 years of age included:
- developed and monitored nutrition component of the credentialing process for School Based/School Linked Health Centers (SBSLHC);
- added a nutrition performance measure to School Health Center contracts and agreement addenda that will require a follow up BMI-for-age assessment within 12 months for all enrolled students of School Health Centers who have medical record documentation that they have been assessed as underweight or at risk for overweight;
- offered training to state nurses on pediatric obesity prevention at the annual Child Health Update conference;
- participated in the planning of a nutrition education component at the North Carolina Healthy Schools Institute; and
- used results of formative research on the second phase of the Students Eating Smart and Moving More (SESAMM) pilots to make recommended revisions and continue pilots in the 4 School Based Health Centers.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhancement of Nutrition and Physical Activity Surveillance System.				X

2. Provide local funding for community-based interventions on healthy eating and physical activity.		X		
3. Continue partnering with the DPH Physical Activity and Nutrition Branch on CDC grant-funded activities.				X
4. Education of health care professionals on a variety of strategies.				X
5. Education of children and their parents/caretakers.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/During FY08, activities undertaken by the C&Y Branch and NSB to promote healthy weights among children 2-18 years of age include:
- providing continuous quality improvement to the nutrition component of the C&Y Branch's clinical based SBSLHC program;
- offer training on Food Marketing to Kids for those who specialize in child health care at the annual Child Health Update conference;
- continuing the collaboration with DPI on implementation of USDA-required local school wellness policies and school nutrition standards;
- developing the SESAMM Resource Kit for distribution to Registered Dietitians providing nutrition education to middle and high school students;
- continuing to coordinate routine School Health Nutritionists Network discussions for school health nutritionists throughout the school year to network, provide technical assistance, share updates/resources, and promote professional development; and
- presenting project outcomes of local youth/adult teams who attended the SESAMM Youth Summit '06 and received a maximum of $1000 from the C&Y Branch to implement nutrition/physical activity initiatives in their schools and local communities at a roundtable presentation during the 135th APHA Annual Meeting & Exposition (November 3-7, 2007) in Washington, DC.//2009//

c. Plan for the Coming Year

/2009/Activities planned by the C&Y Branch and NSB for FY08 to promote healthy weights among children 2-18 years of age include:
- continuing the collaboration with DPI on implementation of USDA-required local wellness policies and school nutrition standards;
- promoting toolkit to support implementation of local wellness policy in schools;
- promoting toolkit to promote school meals as the healthy, low-cost choice;
- providing training on implementing local wellness policy to school systems and community partners; and
- developing nutrition education curriculum for middle school.//2009//

State Performance Measure 5: *The percent of women responding to the Pregnancy Risk Assessment Monitoring System (PRAMS) survey that they either wanted to be pregnant later or not then or at any time in the future.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	40	40	40	39	39

Annual Indicator	40.6	42.2	44	44.4	47.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	38	38	38	38	38

Notes - 2007
Data are for CY06. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

Notes - 2006
Data are for CY05. Due to low response rates in the later part of 2005, the 2005 North Carolina PRAMS dataset represents January through August births only. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

a. Last Year's Accomplishments
/2009/ 2006 data from the Pregnancy Risk Assessment Monitoring System (PRAMS) show that 47.6% of pregnancies were unintended. This is a slight increase when compared to CY06 (44.4%) and CY05 (44%) and the weighted data for 1999-2003 (42.5%). The current rate is also higher than the 2010 objective (43%) in the Logic Model adopted by the Women's Health Branch (WHB). There is not a clear explanation for the causes of this increase at this time, but what is clear is that this indicator has been increasing for the past five years.

The Family Planning and Reproductive Health Unit (FPRHU) continues to provide comprehensive family planning services through a network of approximately 140 service sites throughout the state. These sites served 138,076 unduplicated patients in CY07. This number declined by 5.04% compared to the previous year's total, and represents the first reduction in patient numbers in the past five year. A number of plausible explanations for this decline include increased competition from local providers who offer free or low cost services, local staff reductions from retirements, an aging workforce, difficulty in replacing/hiring qualified staff, increased cost of delivering services, and increased utilization of limited clinic time/schedules while serving increasing numbers of non-English speaking clients. To help reverse this declining trend, in CY07 the FPRHU, distributed, on a formula and need basis, over $500,000 to qualified local agencies to initiate outreach, marketing, and other strategies to increase caseload.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Full implementation of the 1115(a) demonstration waiver (Medicaid waiver).				X
2. Continuation and expansion of the Hispanic/Latino Outreach Initiatives.		X		
3. Continuation and expansion of special outreach initiatives, particularly to teen patients.		X		
4. Continuation of sterilization funding and services.				X
5. Continuation of TPPI, with greater emphasis on programs for Hispanic/Latino youth.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities

/2009/The FPRHU is in the third year of a 1115(a) Medicaid Demonstration Waiver which extends eligibility for family planning services to women (age 19-55) and men (age 19-60) with incomes at or below 185% of the federal poverty level regardless of receipt of previous Medicaid reimbursed service (pregnancy-related or otherwise). The major goal of the waiver is to reduce unintended pregnancies and improve the well being of children and families in NC. Among several objectives, two target reductions in the number of inadequately spaced pregnancies and in the number of unintended and unwanted pregnancies among women eligible for Medicaid. As of the second year of implementation (SFY07), 7,550 patients were served by local health department family planning clinics. However, the total patients served by all approved providers for both new enrollees and continuing clients from year one were 41,520 females and 7,873 male patients.

The significant increase in the Hispanic population of the state continues to be a challenge for local maternal health and family planning clinics. To help meet this challenge, the FPRHU continues to fund the Latino Family Planning Outreach Initiative with $500,000 in special Title X funds used for special projects in local public and private not-for-profit agencies located in communities with large Hispanic/Latino populations. In FY08, three new community-based agencies were funded, bringing the total number of special projects to seven.//2009//

c. Plan for the Coming Year

/2009/The FPRHU will continue the implementation of the 1115(a) Medicaid demonstration waiver. Implementation of the evaluation component of the Medicaid waiver begun in FY07 is starting to yield positive results. Measured in terms of budget neutrality, the reduced costs associated with the estimated range of 1,435 to 1,653 averted births offset the costs of the waiver by an estimated $14.3-$17.1 million. Subsequent data from the evaluation will be carefully analyzed by Unit staff and Division of Medical Assistance staff, and results will help shape future activities for the Medicaid waiver.

In response to the declining patient census, the FPRHU will continue to conduct a more systematic analysis of patient and general population trends and collect qualitative data from key informant interviews to help determine the main reasons for the decline and to design appropriate interventions.

Regional Consultant staff reorganization due to a number of staff retirements will continue to be refined and activities and responsibilities added as the waiver is implemented. Accountability issues will also be a major focus, particularly as they relate to local contracts which now must reflect specific intermediate outcomes in the logic models. The emphasis on increasing patient census, particularly teens, will continue. The TPPI will continue to expand with the restoration of TANF funds. This is significant in light of the high rates of out-of-wedlock births and unintended pregnancies among teens.

The FPRHU will also continue to implement the specific action steps prescribed for the unit in DPH's Recommendations for Eliminating Health Disparities.//2009//

State Performance Measure 6: *Percent of women of childbearing age taking folic acid regularly.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	50	50	50	50	50
Annual Indicator	42.2	47.1	47.1	38.5	38.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	50	50	50	50

Notes - 2007
Data is a repeat of the 2006 BRFSS data. 2007 BRFSS data are not available for this indicator.

Notes - 2006
Data source is the 2006 NC Behavioral Risk Factor Surveillance System. Unweighted numerator and denominator are not available.

Notes - 2005
2005 data are not available as the folic acid module was not included in the state's BRFSS for this year. As an estimate has to be entered into the data system, the CY04 data value was entered, but there is no way to know if this is a good estimate or not.

a. Last Year's Accomplishments
/2009/Activities undertaken in FY07 included expansion of outreach to 18-24 year-old women via social networking sites, continuation of direct outreach and media campaigns, and continued emphasis by regional coordinators on integrating folic acid education into existing programs. The Latino campaign focused efforts on community education and trained hundreds of women using a peer health education model. Activities for National Folic Acid Awareness week in January also focused on this population that is twice as likely as other groups in North Carolina to suffer from neural tube defects. Approximately 250 Latino outreach sites (tiendas, laundromats, etc.) were reached by volunteers and 5,000 Spanish-language materials were distributed during that week alone. The NC Family Health Resource Line staff was trained to enhance the distribution of materials. Finally, a comprehensive campaign evaluation was launched and focused on surveying both Spanish-speaking women of childbearing age and health care providers who participate in the Office Champion program.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Education of health care professionals via a variety of strategies.				X
2. Education of consumers and reminders to take a multivitamin daily.			X	
3. Mass media and public awareness activities.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/Current efforts include continuing the implementation of existing health care provider education activities with an additional focus on reaching health care providers in training (dental hygienists, public health students, health promotion students, etc.) and assuring that multivitamin prompts are incorporated into as many standard clinical forms as possible. The NSB distributed correspondence to Local WIC Programs highlighting available folic acid education materials and an article addressing strategies to reach folic acid "non-users". The peer health education program continues with both English and Spanish-speaking community members across the state. A new brochure is currently under development and distribution of new materials developed last year (English and Spanish-language postpartum brochures) is underway. Of special note is the successful integration of the multivitamin/folic acid message into health education provided to all deploying and returning soldiers at Ft. Bragg. The campaign continues its leadership role in the development of a comprehensive statewide preconception health plan as well. Regarding evaluation, the North Carolina State Center for Health Statistics released data in late 2007 that examined the state's neural tube defect rates over a 10-year period. These data show that North Carolina experienced a 40 percent drop in the prevalence of neural tube defects between 1994/1995 and 2004/2005.//2009//

c. Plan for the Coming Year

/2009/Planned activities for FY09 will focus on the continued implementation of existing programs. Regional coordinators will continue to train both lay health educators and professional health care providers through the Office Champion and Community Ambassador programs. Media campaigns will continue in English and Spanish and development of new materials and reminder items will proceed as necessary. A major redesign of the campaign's web site, www.getfolic.com, will be introduced in mid-2008.//2009//

State Performance Measure 7: *The ratio of school health nurses to the public school student population.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	1:1900	1:1700	1:1500	1300	1200
Annual Indicator	1,918.1	1,897.2	1,593.1	1,571.3	1,340.8
Numerator	1279768	1311163	1332009	1363695	1386363
Denominator	667.2	691.1	836.1	867.9	1034
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	1200	1150	1150	1100	1100

Notes - 2007

As colons aren't allowed in the measure, the number listed in the objectives is the second number of the ratio (1:1918, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY06 Students: 1,363,695 School Nurse FTEs: 867.9; ratio 1:1571
FY07 Students: 1,386,363 School Nurse FTEs: 1034; ratio 1:1341

Notes - 2006

As colons aren't allowed in the measure, the number listed in the obejectives is the second number of the ratio (1:1918, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY05 Students: 1,332,009 School Nurse FTEs: 836.06; ratio 1:1593
FY06 Students: 1,363,695 School Nurse FTEs: 867.9; ratio 1:1571

Notes - 2005
As colons aren't allowed in the measure, the number listed in the obejectives is the second number of the ratio (1:1918, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY03 Students: 1,279,468 School Nurse FTEs: 667.24; ratio 1:1918
FY04 Students: 1,311,163 School Nurse FTEs: 691.11; ratio 1:1897
FY05 Students: 1,332,009 School Nurse FTEs: 836.06; ratio 1:1593

a. Last Year's Accomplishments
/2009/During FY07, the 2006-07 North Carolina Annual School Health Services (NC ASHS) report for Public Schools was distributed to school nurses, key decision-makers in local and state government, statewide advocates for school health, and the media, and was also made available on the www.nchealthyschools.org website. The six Regional School Nurse Consultants (RSNCs), along with the state School Nurse Consultant, continue to monitor progress of the School Nurse Funding Initiative (SNFI) which began in 2004-05. One of the requirements for local health departments, school systems, and hospitals receiving SNFI allocations is to develop individualized Action Plans for each of the funded nurses. The RSNCs work with local school health programs to assist the funded nurses in developing Action Plans, monitoring their progress, and completing the SNFI Annual Report. The Annual Report addresses the overall progress toward meeting outcomes, detailing the activities and strategies utilized in six basic school health service areas. Several LEAs have adapted the Action Plan for their non-SNFI nurses.

In addition to working with school systems employing SNFI nurses, the RSNCs continue to work within their regions to promote the development and expansion of school health services. They collaborate with representatives of other components of the Coordinated School Health Program such as teachers, school administrators, PTA members, students, community leaders, and state agencies and organizations. The RSNCs also collaborate with AHECs and the NC Institute for Public Health to plan, develop, implement and evaluate continuing education activities for school nurses across the state. Regional and state school nurse consultants conducted site visits of school based health centers and reviewed sections of the credentialing assessments. Workshops on Case Management, Pediatric Physical Assessment, Orientation for New School Nurses, Managing Asthma Triggers, School Nurse Certification Review, the Annual School Nurse Conference, and the second half of a bi-annual School Nurse Leadership Institute were offered to school nurses across the state.

In School Year 2006-07, the School Nurse to Student ratio was recorded as 1:1,340, reflecting improvement in this measure.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of program agenda for Annual School Nurse Conference and other continuing education offerings.				X
2. Clinical and administrative consultation, training and technical assistance to school districts, local health departments, and hospitals.				X
3. Collection and analysis of data regarding health needs, resources and program services.				X
4. Development of standards, guidelines and procedures.				X
5. Dissemination of new nursing and school health related information.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/The NC ASHS is used to support recommendations for increased school nurse positions. In the summer of 2007, the NC General Assembly allocated money to increase the number of school nurses by 66, and most of these nurses began employment in November 2007.

The School Health Unit utilized information from the NC ASHS to identify trends in student needs and service delivery models. An outcome of this review is increased collaboration with other providers of health services in the schools, including dental health, mental health, behavioral health, and services to increase physical activity and improve nutrition. A review of the functions of School Health Advisory Councils resulted in increased attention to these councils during site visits and nurse performance reviews. Site visits and technical consultation also resulted in increased attention to the school system's Communicable Disease Prevention Plans, particularly the blood-borne pathogen exposure control plan.

The school nurse consultants contributed to the revision of the KHA and to the Immunization Branch's communication plan for new vaccine requirements. They also promoted referrals to the Early Childhood Vision Care Program. The RSNCs provided professional nursing guidance to the school nurses working in the Child and Family Support Team program, served on the statewide CFST Advisory Committee, and provided assistance to the Asthma Alliance of NC and the NC Diabetes Advisory Council.//2009//

c. Plan for the Coming Year

/2009/The state and regional school nurse consultants will continue activities previously described: continue to monitor the SNFI nurses by reviewing and approving their Action Plans at the beginning of the school year, having mid-year discussions about progress, and reviewing annual reports at the conclusion of the school year. They will continue to provide consultation to the school nurses working in the Child and Family Support Team program and to the school based health centers. The RSNCs will continue to serve on committees that affect school health, such as the Asthma Alliance of NC, the NC Diabetes Advisory Council, the School Nurse Association of North Carolina, NC Tobacco Free Schools Task Force, and the Kindergarten Health Assessment Social Norms Marketing Task Force. The RSNCs will work with the School Health Matrix Team through planning and participating in the events and projects of that Division-wide partnership.

The state and regional school nurse consultants will review the continuing education opportunities that they plan in partnership with NC Institute of Public Health and the NC AHECS. A strategy for this review will be a workshop in which they will learn about new ways of learning and how to assess the content and delivery of that education. The workshop will enhance their skills as they continue to develop, promote, and evaluate continuing education opportunities for school nurses statewide.

The 24th Annual School Nurse Conference will be held in September 2008.

Data from the NC ASHS report will continue to be summarized, analyzed and used to identify trends in student needs and service delivery and to support recommendations for improving the student to school nurse ratio, a priority goal of DPH. The successful implementation of any legislative action for that goal will be a key activity in the coming year.//2009//

State Performance Measure 8: *Percent of women with live, term births who gain within the Institute of Medicine (IOM) Recommended Weight Gain Ranges.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				34	35
Annual Indicator	33.2	33.0	33.6	33.0	32.9
Numerator	11880	11664	12429	12227	12959
Denominator	35823	35361	36981	37012	39331
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	36	37	38	38	38

Notes - 2007
Data are based on prior CY (FY07 is really CY06). As per the detail sheet, these data are only available for women receiving WIC services.

Notes - 2006
Data are based on prior CY (FY06 is really CY05). As per the detail sheet, these data are only available for women receiving WIC services.

a. Last Year's Accomplishments
/2009/During FY07, Healthy Weight Healthy Women (HW2) activities to promote appropriate gestational weight gain included revisions and/or additions to educational materials to assure consistent messages regarding appropriate gestational weight gain, inclusion as a main topic in the first electronic newsletter for statewide high risk maternity clinics, and ongoing technical assistance to maternal health clinics regarding pre-pregnancy BMI assessment so as to determine gestational weight gain guidance. Changes to the Maternal and High Risk Maternal Agreement Addenda included additional guidance added to the gestational weight gain related process outcome objective (POO) reflecting recent advice to recommending, as appropriate, gaining less than the minimum weight gain recommendation for obesity class III patients.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Staff training.				X
2. Client education and awareness.		X		
3. Anthropometric data collection and assessment.	X			
4. Data analysis.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/HW2 has been incorporated in the current collaboration around preconception health, as "overweight/obesity in women" emerged as one of the top two topics to address in that collaboration. A new workgroup, Weight in Women (WOW), has formed and will continue and expand upon HW2 goals which include promoting appropriate gestational weight gain.

Regular communication has now been established among high risk maternity clinic nutritionists. Discussion about strategies in managing the overweight or obese prenatal client is shared.//2009//

c. Plan for the Coming Year

/2009/Activities in 2009 include revising the maternal health flow sheet and the prenatal weight gain grid to allow space for recording body mass index. WOW focus will include education and training for health professionals to encourage appropriate gestational weight gain and food system assessments of high risk neighborhoods to determine interventions for promoting healthy weight in women before, during, and after pregnancy.//2009//

State Performance Measure 9: *Percent of non-pregnant women of reproductive age who are overweight/obese (BMI>26).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				45	44
Annual Indicator	44.9	45.9	46.3	46.6	46.7
Numerator	18366	18600	19693	20048	21109
Denominator	40905	40522	42533	43022	45201
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	43	42	41	40	40

Notes - 2007

Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates.

Notes - 2006

Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates.

a. Last Year's Accomplishments

/2009/During FY07, Healthy Weight Healthy Women (HW2) activities to promote weight management in women included revisions and/or additions to educational materials to assure consistent messages regarding healthy weight for women and ongoing technical assistance to family planning and maternal health clinics regarding body mass index (BMI) assessment and guidance. Changes to the Family Planning Agreement Addenda highlighted BMI assessment as necessary in identifying and addressing weight issues in women.//2009//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Client assessment.	X			
2. Client education.		X		
3. Staff training.				X
4. Data collection and assessment.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2009/HW2 has been incorporated in the current collaboration around preconception health, as "overweight/obesity in women" emerged as one of the top two topics to address. A new workgroup, Weight in Women (WOW), has formed and will continue and expand upon HW2 goals to promote healthy weight in women.//2009//

c. Plan for the Coming Year

/2009/Activities planned for FY09 include revising the maternal health flow sheet and the prenatal weight gain grid to allow space for recording BMI. WOW has identified three priority areas of focus: education and training for community health workers/lay health advisors who come in contact with women of reproductive age in promoting healthy weight, the examination of obesity and effective contraceptive use, and food system assessments of high risk neighborhoods to determine interventions for promoting healthy weight in women before, during, and after pregnancy.//2009//

E. Health Status Indicators

/2007/The WCHS uses the Health Status Indicators (HSI) in a variety of ways. They provide information on the residents of NC which assists in public health efforts, but they are used by the WCHS primarily as a surveillance or monitoring tool as they are updated each year for the MCH Block Grant application and as evaluative measures. Taken as a whole, they were certainly an important part of the data reviewed during the five-year Needs Assessment process. The attached Excel worksheet was created early during the process and referenced by the Needs Assessment Team throughout the process.

In addition, many individual HSI are used for monitoring purposes. Some are cited in the WCHS Logic Models as intermediate or end outcomes (e.g., reduce child deaths due to unintentional injury and decrease the percent of live births weighing less than 2500 grams). Logic models have been created for each of the WCHS Core Indicators for use in performance based contracts and are updated annually.

Other indicators are used in community monitoring sessions at local health departments. Child health and women's health nurse consultants and social work consultants work together in teams to provide program consultation to county health department and community agency staff. County and state level data are available for use in these monitoring sessions.

In addition, some of the indicators were used in the Shared Indicators for School Readiness project which is part of the Early Childhood Comprehensive Systems grant.

The Health Status Indicators used by the WCHS have been a substantial influence on the Division of Public Health's efforts to implement a statewide accountability process. It is hoped that in this way the HSIs will have a substantial impact thoughout public health in North Carolina by promoting the use of data in public health management and decision-making and in promoting accountability.//2007//

F. Other Program Activities

MCH Hotline - NC's Family Health Resource Line has evolved from a prenatal care hotline to a multi-program resource. The hotline averages 3,500-4,000 calls a month and operates during general office hours on weekdays. It offers bilingual and TTY services, and offers information, referral, and advocacy services.

In 1990, NC launched First Step, an infant mortality public awareness campaign, which included a statewide toll-free number. The line responded to calls related to preconceptional, prenatal, postpartum, and infant care; breastfeeding and nutrition; and Baby Love (Medicaid for pregnant women). In 1994, the Health Check Hotline (Medicaid for children) was launched. The line was co-located with the First Step Hotline, using the same staff but a separate toll-free number. With this expansion, the hotline's mission broadened to encompass child health topics. That same year, the First Step Hotline added a focus on prenatal substance use prevention and treatment. In 1998, programs pooled resources to create the NC Family Health Resource Line. The state's Smart Start Program, a public-private initiative that provides early education funding to all of the state's counties, became a partner and contributed early child development and parenting resources, and the Health Choice Program (SCHIP) marketed the line as their "call to action" to learn more about free and low-cost health insurance. In 2002, the NC Child Care Health and Safety Resource Center was merged into the NC Family Health Resource Line, again expanding breadth of services and resources. The NC Family Health Resource Line is funded by state dollars, federal Medicaid matching dollars and MCH grant funds.

The Family Health Resource Line is now administered through the University of North Carolina at Chapel Hill. There are 12 individuals who staff the consolidated lines and the resource center. Families with young children who have developmental concerns or other special health care needs are linked to services directly and referred to the Title V CSHCN hotline and the Early Childhood (Part C) hotline, which is operated (but not funded) by Title V.

Targeted campaigns have increased public awareness of the line, most notably the "First Step" campaign to reduce infant mortality, "Back to Sleep" SIDS-prevention, "Veggies and Vitamins" birth defects prevention, and "Health Check/Health Choice" child health insurance campaign. As hotline administrators noted, the hotline must be continuously marketed to be effective.

Collaboration is a key strength of the NC Family Health Resource Line. The hotline is one of the

few that has an advisory committee exclusively dedicated to oversight. Members of the committee include representatives from UNC-Chapel Hill, Title V, Medicaid, CSHCN, the resource line and other key lines. With the hiring of a full-time parent liaison in the C&Y Branch and her work with the Family Advisory Council, the resource line will have greater parental involvement.

The hotline also serves as a key policy tool in that it helps MCH staff identify populations served, the success or failure of outreach efforts, service gaps, and barrier issues. Frequently staff learn about programmatic issues from callers. For example, the state's SCHIP program initially had a 2-month uninsured waiting period. Through the hotline, staff learned that families of children with special needs were choosing to go without insurance to qualify for the more comprehensive, public health insurance. With this data, the program eliminated the uninsured waiting period.

The hotline also offers advocacy services beyond those typically offered, as it links families with medical assistance and resolves barrier issues. Through calls to the line, program staff can identify procedures that are not being implemented appropriately at the local level or by the insurance intermediary.

The NC Sudden Infant Death Syndrome (SIDS) Program is administered through the WHB. Grief counseling and support services are provided to families who have lost an infant to either suspected or confirmed SIDS by either a local or regional SIDS Counselor. Educational outreach and prevention awareness services are provided to health care providers, child care providers, community groups, and first responders. In FY99, the SIDS Program continued to expand its efforts to support primary prevention of SIDS deaths by promoting public awareness of the importance of proper infant sleep positioning. The campaign was designed to complement the national "Back to Sleep" campaign by ensuring access to national public education materials through the hotline and other local sources. A photo-novella targeting African American multigenerational families was developed and distributed which received very positive reviews.

/2007/ The "Back to Sleep" campaign continues. In FY2006, the photo-novella targeting African American multigenerational families was revised, reprinted, and distributed to continue to promote placing babies on their backs to sleep.//2007//

G. Technical Assistance

See Form 15 for specific technical assistance requests.

V. Budget Narrative

A. Expenditures

/2006/ Total state partnership expenditures in 2004 were more than $20 million over 2003. The primary reasons for this were the inclusion of over $12 million in dental health services for children paid by the state Medicaid program in local health departments. These expenditures were not reported in 2003, so this is not necessarily a true increase in expenditures. Another major difference was the increased expenditure of infant formula rebates for recipients of WIC services. This was a true increase amounting to approximately $5 million. Expenditures of MCH Block Grant funds accounted for about $2 million of the total increase./2006/

B. Budget

/2004/The most significant change in North Carolina's MCH Block Grant budget/expenditure plan for FY02 was to change the way the state accounted for the federal funds and the required match, and secondly the way the federal funds were drawn from open awards. Before FY02, the state had budgeted/expended all the federal funds in unique cost centers that identified funds as 100% MCH Block Grant dollars. State funds used for MOE/match were budgeted and expended in different cost centers. This allowed the Title V agency to designate federal funds into program areas that would help maintain the 30%/30% requirements. However in FY02, the state required that all state match for the grant be budgeted in the same cost center with the relevant federal dollars. Upon expenditure of those pooled dollars, the state drew the appropriate number of federal dollars to reflect the 4:3 match rate. While this method assured the state of meeting the required match, it created a challenge for the agency to align budgets for supported programs to continue to meet the 30%/30% set asides. However, this was achieved and the attached table (FY03 MCH Block Grant Budget Justification by Program/Activity by Type of Service) reflects the distribution of Maternal and Child Health Block Grant funds anticipated in 03-04 according to the targeted programs.

A second change occurred in FY02 that was concurrent with the change in the accounting method. Before FY02, the expenditure of MCH Block Grant funds could be designated from particular awards. This practice led to large unobligated balances after the first year of an award, as expenditures were charged to the new grant at the time of the award. The state had to then designate unobligated funds for relevant maternal and child health projects to insure the expenditure of those funds in the second year of the budget period. In FY02, the state began expending funds from the earliest open grant award on a first in, first out basis. This assured the state that the full amount of the award would be expended by the end of the second year of the budget period.

The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $39,427,038. This includes state funds used for matching Title V funds, which, for the FY04 application, is $12,887,306.//2004//

/2005/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $38,515,199. This includes state funds used for matching Title V funds, which, for the FY05 application, is $13,143,054.//2005//

/2006/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $41,825,405. This includes state funds used for matching Title V funds, which, for the FY06 application, is $13,077,417.

The attached table (FY06 MCH Block Grant Budget Allocation of Funds by Program/Activity by Type of Service) reflects the distribution of Maternal and Child Health Block Grant funds anticipated in 05-06 according to the targeted programs.//2006//

/2007/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $51,372,967. This includes state funds used for matching Title V fund, which for the FY07 application, are $12,611,401. Primary reasons for the increase include increased state funding for school nurses and vaccines.//2007//

/2008/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $59,548,401. This includes state funds used for matching Title V fund, which for the FY08 application, are $12,611,401. The primary reason for the increase in state funds is increased appropriations for vaccines for childhood diseases.//2008//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.